

THE PARTNERSHIP PLAN

A Public-Private Initiative Ensuring Healthcare for Needy New Yorkers

**Presented to the
Secretary of Health and Human Services
and the
Administrator of the Health Care Financing Administration**

by

**The State of New York
George E. Pataki, Governor**



STATE OF NEW YORK
EXECUTIVE CHAMBER
ALBANY 12224

GEORGE E. PATAKI
GOVERNOR

March 17, 1995

Dear Secretary Shalala:

I am submitting on behalf of the State of New York an application under Section 1115 of the Social Security Act for approval of a Demonstration Project to implement a statewide managed care program. This project is an integral element of the State's overall strategy for reforming and restructuring its health care programs to comport with available state resources, to improve the system of delivery of health care, and to provide for more responsive and focused care that is likely to produce better health outcomes for those in need of health care services.

The submission of this application follows the completion of a process of public meetings, comment and involvement that was previously approved by your Health Care Financing Administration as consistent with your Department's policies on public participation in section 1115 demonstration project development.

In our Demonstration Project, we combine the existing Medicaid population (other than the elderly and disabled that are served in institutional settings or in alternative arrangements, and certain other excluded categories) together with the Home Relief population (those that are financially needy but do not meet federal categorical eligibility requirements), and provide for their health care through a system of managed care networks that will be selected after a competitive bid process and will be paid on a capitated basis. We believe that this reliance on private market structures will lead to greater reliance on primary and preventive care and less use of inappropriate and costly alternatives. At the same time, we are building a sound quality assurance system into our project, to assure that the promise of higher quality care and better health outcomes is realized.

For those populations that have special needs and require more intensive services, our project will utilize special needs plans, which also will be focused on managing the care of their enrollees and will be paid for on a capitated basis.

We have considerable experience with managed care in New York, and we believe the capacity is available to handle the additional caseload that we propose to make available to that method of care. Further, our proposal will meet federal budget neutrality standards. It is my hope that we will be able in New York to effect significant savings in the overall level of Medicaid spending. The demonstration project will assist in that effort, both by making it possible to deliver necessary services in a more cost efficient manner and by enhancing the quality of service provided and improving the health of the people that we serve.

We in New York are committed to begin implementation of the program this year, and we therefore are asking that your Department give priority attention to our proposal. Dr. Barbara DeBuono, Commissioner of Health, and Mary Glass, Commissioner of Social Services, are jointly responsible for the overall direction of the Demonstration Project. I ask that you and your Department work with them in the waiver approval and implementation process. They fully understand and are in accord with the importance of early action on our proposal and are prepared to respond immediately to any requests of your staff.

We look forward to working with you and your Department in the speedy processing of our application and in the implementation of the demonstration program.

Very truly yours,



Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue
Washington, D.C. 20201

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CHAPTER THREE

PROGRAM ADMINISTRATION AND MANAGEMENT

The State is planning a reorganization which will centralize the management and oversight of the demonstration project along with key functions related to the managed care program in the Division of Managed Care within the Department of Health (DOH). The purpose of **this** reorganization is to provide a single point of accountability, streamline the decision-making process, build the necessary infrastructure to support a statewide demonstration project, and consolidate the resources that support the program.

The following sections of this chapter describe the current organization, present the proposed organizational structure, and outline the schedule and work plan for implementing the demonstration project.

A. Present Organization

Under the Statewide Managed Care Act of **1991**, the Department of Social Services designated each of the local DSS agencies within the State to develop and submit Medicaid managed care plans in three phases beginning in the **fall** of **1991**. Since that time, the Department has continued to operate the voluntary managed care program while the various counties have been developing and implementing their respective plans for complying with the Statewide Managed Care **Act**. The Human Resources Agency (HRA) in New York City operates the only mandatory program within the State under a demonstration waiver for a portion of southwest Brooklyn.

DSS currently has primary responsibility for overseeing and administering the managed care efforts to date. However, the Department of Health, the local DSS agencies, HRA in New York City, and other entities participate in a variety of roles. The following sections describe the roles and responsibilities of each entity in the current organizational structure for the Medicaid program.

1. *Department of Social Services (DSS)*

The New York Department of Social Services is the single state agency responsible for the Medicaid program. Currently, DSS also oversees the development and implementation of managed care under the Statewide Managed Care Act of **1991**. Within the Department, the major responsibilities for the Medicaid program are located in the Division of Health and Long Term Care as follows:

- Office of the Deputy Associate Commissioner -- This office is responsible for administration/personnel issues, Robert Wood Johnson Partnership for Long Term Care, program impact monitoring, and management reports and research.

- Bureau of Primary Care -- This bureau is responsible for managed care for Medicaid recipients, comprehensive Medicaid case management, maternal and child health programs, and special projects.
- Bureau of Ambulatory Policy and Utilization Review -- This bureau has responsibility for ambulatory, acute care, and transportation policy; utilization thresholds; recipient restriction program; **drug** utilization review (DUR), and pharmacy policy and operations, and OMH and **OASAS** interface.
- Bureau of Eligibility and Resources -- This bureau is responsible for Medicaid eligibility and policy, third party policy, NYC operations, and disability reviews for State programs.
- Bureau of Long Term Care -- This bureau is responsible for **all** long term care policies and programs, home care personal care, institutional long term care, and **AIDS** policy coordination.
- Bureau of MMIS Operations Management -- This bureau is responsible for MMIS operations; interface with the fiscal agent, Computer Sciences Corporation (CSC); communications with providers; out-of-state **MMIS** billing; and provider enrollment.
- Office of Disability Determinations -- This office is responsible for medical determination of eligibility for federal Social Security and the Supplemental Security Income Program.

Additional functions related to Medicaid are performed throughout the Department as follows:

- Office of the Commissioner -- The Office of the Commissioner is responsible for intergovernmental relations and external affairs, communications with the media and public relations, strategic planning, overall program policy direction and management, and internal audit.
- Division of Legal Affairs -- **This** division supports the Medicaid Program through legislative and regulation development, litigation, review of deferrals **and** disallowance, Fair Hearings, and rate reconsiderations.
- Division of Services and Community Development -- This division assists the Division of Health and Long Term Care in setting Medicaid rates for children in foster care. A separate project involves the testing of a managed care model in foster care.
- The Office of Housing and Adult Services -- This office develops community-based services for elderly and disabled adults.

- The Division of Economic Security – This division is involved in Medicaid eligibility related issues for public assistance applicants and recipients and requires medical examinations prior to the determination of employability.
- Office of Field Operations – Included within this Office is responsibility for the coordination and support of local district eligibility functions including Medicaid, training, quality monitoring and improvement programs, implementation of policies and procedures, and communication with local districts and outside entities.
- Division of Management Support and Quality Improvement -- This division provides a full range of administrative services to DSS, including personnel management, training, management consulting, financial management, purchasing, and contract management. The division's Office of Quality Assurance and Audit is responsible for ratesetting, auditing, and fraud prevention and detection for a variety of Medicaid providers.
- Division of Systems Support and Information Services -- This system supports the MMIS and Medicaid eligibility through Welfare Management Systems. Also designs, develops, installs and maintains the computer system for Department and local district users.

The current organization of **DSS** is shown in Appendix 3.

2. *Department of Health (DOH)*

Currently the Department of Health also performs various activities related to Medicaid. **DOH** is responsible for establishing and maintaining standards for providers, reviewing and certifying managed care plans, developing reimbursement rates, advising and assisting DSS in establishing a uniform system of reports relating to quality of medical care, reviewing and auditing quality and availability of medical care and services under the State plan, and providing consultative services to Medicaid providers. In addition, DSS has entered into a cooperative agreement with DOH whereby DOH administers and supervises the medical care and health services available to Medicaid eligibles.

- Office of Health Systems Management (OHSM) -- OHSM is responsible for assuring that quality medical care is available to New Yorkers. OHSM's Division of Health Care Standards and Surveillance adopts and implements health care standards and conducts surveillance programs to ensure that quality patient care, appropriately utilized, is delivered by the State's health care system. This includes Medicaid utilization review through a contractual relationship with Island Peer Review Organization (IPRO); review of Certificate of Need applications; oversight of the quality of care delivered by long term care facilities; certification and regulation of **PHSPs** and **HMOs**, including review of clinical and other services; oversight of hospitals and free-standing clinics, including FQHCs; coordination of

the Department's Medicare/Medicaid certification program; and oversight of the survey and certification of ICF/MRs.

The Division's Bureau of Alternative Delivery Systems is currently the primary program unit responsible for managed care oversight. The Division also reviews medical services provided to Medicaid recipients to ensure such services are cost-effective and appropriate, through its prior approval, pended claims review and automated claims editing. OHSM's Division of Health Care Financing develops and implements systems of health care reimbursement. The Division's Bureau of Community Health Insurance and Finance Systems works with DSS to plan and implement the State's managed care project. The Bureau, in cooperation with DSS, develops the reimbursement rates and is involved in the analysis and negotiation of each Medicaid managed care contract. OHSM's Division of Health Facility Planning administers the State's CON program.

- Office of Quality Improvement -- This office is DOH's focal point for assessing and improving health care quality in the State. The office is working with providers and consumers to identify opportunities for improving quality in the health care system, generating information about care patterns, and making this information available to assure the best possible health care decisions. This includes quality measurement initiatives, the development, implementation, evaluation and uses of practice guidelines and technology assessment, and technical assistance.
- The Division of Planning, Policy and Resource Development -- This division analyzes major issues and problems in public health, health systems, and health care finance. It advises the Commissioner and her executive staff on health policy and resource development issues. The division also helps to identify goals and objectives for DOH and formulates policies and programs to achieve them.
- The Office of Public Health -- The Office of Public Health protects and promotes the health of New Yorkers through population-based prevention efforts including education, research, and prevention of injuries and disease. Many of the programs administered by OPH aim to enhance child growth and development through early prenatal care, newborn screening, immunization, and school health programs. The Division of Family Health, in the Center for Community Health, administers a broad array of programs addressing perinatal care, child and adolescent health, family planning, dental health, chronic disease prevention and early detection and the health of the elderly. These programs are targeted to families at greatest risk of adverse health outcomes. The **AIDS** Institute coordinates the State's response to the HIV/AIDS epidemic. The Institute initiates, develops, and funds HIV prevention and health care programs, educates the public and health care providers, formulates policy, and directs regional and statewide HIV/AIDS planning.

Appendix 3 also includes a chart depicting the current organizational structure of **DOH**.

3. *Other Agencies*

The following agencies also have responsibilities that relate to Medicaid:

- **Office of Mental Health (OMH)** – OMH's primary mission is to develop and support a coordinated, comprehensive, and community-based public mental health system. New York's public mental health system includes State-operated, **certified**, and funded programs as well as locally funded and operated programs. State facilities include twenty adult psychiatric centers, **six** children's psychiatric centers, three forensic centers, and two research institutes. In addition to State facilities, there are over **2,500** programs **serving** adults and children throughout the State. These include **family** care, community-based inpatient programs, outpatient programs, community residence programs, and residential centers for adults. **OMH** primarily serves adults who are seriously mentally ill and who have experienced substantial problems in independent functioning and children with serious emotional disturbance (**SED**).
- **Local departments of social services (LDSS)** and the Human Resources Administration (**HRA**) – New York has a State supervised, locally administered form of organization for the provision of public assistance and care, which includes Medicaid, AFDC, Food Stamps, child **welfare/foster** care and adoptions, adult protective services, and TASA services. The **LDSS** is a department of county administration. In New York City, the **HRA** is responsible for public assistance and care in New York City. Residents within the borders of the LDSS/HRA apply for, are referred to, and receive public assistance and care through these entities.
- **Office of Alcoholism and Substance Abuse Services (OASAS)** -- OASAS is responsible for planning, **funding**, licensing, and monitoring a system of over 1,000 alcohol and substance abuse providers located in hospitals, health clinics, mental health programs, and free-standing community settings, which serve approximately 115,000 individuals on any given day. **OASAS** is responsible for identifying the personal, economic, and social consequences related to the consumption of alcohol and other drugs; designing, implementing, and advocating for policies and programs in prevention, early **intervention**, and treatment; and, in conjunction with local governments, providers, and communities, ensuring that a **full** range of appropriate and needed alcoholism and substance abuse services for addicted persons, family members, and others at risk are available and accessible in the community, providing a continuum of quality programming in a cost-efficient and effective manner.

- Office of Mental Retardation and Developmental Disabilities (OMRDD) -- OMRDD is the State agency charged under the State's mental hygiene law to oversee, plan, and provide services and supports to persons of all ages with mental retardation or other developmental disabilities and to their families. OMRDD ensures the development of comprehensive plans, programs, and services in the areas of research, prevention, care, treatment, rehabilitation, education, and training for persons with developmental disabilities. OMRDD sets standards for quality assurance, develops reimbursement rates, and conducts quality assurance reviews of providers of developmental disabilities services. The OMRDD service system includes both State funded services and Medicaid funded services. The broad array of Medicaid funded supports and services includes ICF/MRs, day treatment, comprehensive Medicaid case management, and services provided through the Home and Community Based Services Waiver and Care at Home Waivers.

4. *Committees/Workgroups*

As part of the existing New York Medicaid Managed Care Program, the following groups were established; the Managed Care Advisory Committee will continue under the demonstration project:

- The Managed Care Advisory Committee – This committee includes broad representation of parties interested in managed care, including fee-for-service providers, the advocacy community, special care providers, and managed care providers. It provides a forum for these stakeholders in managed care to raise issues and concerns, discuss possible solutions, and provide advice and recommendations to DSS and DOH on a wide range of Medicaid managed care issues.
- The Medicaid Managed Care Provider, District, and State Agency Workgroup – This is a workgroup that meets to discuss contract, operational, and technical issues of concern to managed care plans and State and local government staff. Several subcommittees of this workgroup have been reviewing eligibility, enrollment and payment systems, marketing protocols, reporting, and reimbursement rates.

B. **Proposed Organization**

The State is currently undergoing a major reorganization. As part of this effort the State proposes to reorganize the agencies involved in the demonstration project to specifically support the project. Instead of having some people in various divisions and units of DSS and DOH conduct managed care functions, all managed care functions will be performed or overseen by a Division of Managed Care which will be created in DOH.

1. *Proposed Organizational Structure*

The proposed organization for the demonstration project is shown in Exhibit 3.1. The demonstration project **will** be administered primarily by DOH. The managed care unit that is currently located in DSS **will** be transferred to DOH and a Division of Managed Care will be established in DOH. The Division of Managed Care **will** be responsible for conducting or overseeing most of the **functions** associated with the demonstration project. The Division will consist of **three** bureaus: Financing and Contracting; Policy and Research; and Quality Assurance and Utilization Review. The Division will have intergovernmental agreements with DSS, local DSS offices and HRA/Mayor's Office of Medicaid Managed Care, OMRDD, OASAS, and **OMH** to assist with various functions.

DOH **will** be responsible for oversight and quality assurance monitoring of all **AIDS SNPs** and for education and outreach for the HIV/AIDS population. DSS **will** be responsible for fee-for-service claims processing, the **MMIS**, eligibility, and fair hearings regarding eligibility for Medicaid. The local DSS offices will determine eligibility; conduct enrollment counseling; execute contracts with the plans selected from those approved by the State; and choose from various implementation options. DOH will be responsible for licensing **SNPs**, with assistance **from** the **Office** of Mental **Health**. OMH will also develop a comprehensive quality assurance **system** for mental health **SNPs**. OMRDD will be involved in establishing criteria for certifying plans to enroll DD clients. OASAS will assist in developing standards and providing oversight of health plan's substance abuse treatment services.

In addition, the following two standing subcommittees of the Managed Care Advisory Committee will be created to support DOH in its responsibilities under the demonstration project:

- The Waiver Implementation Subcommittee -- **This** committee will be appointed by the Commissioners of DOH and DSS and will consist of representatives from managed care plans; practitioners, consumer/advocacy groups, and project participants. This group will include a representative **from** two subcommittees of this group, one for the **AIDS SNPs** and one for the mental health **SNPs**. This committee **will** provide advice and input regarding implementation and operation of the demonstration project..
- o The Local Advisory Subcommittee -- This committee **will** be appointed jointly **by** DOH and DSS and **will** consist of local **district** commissioners from three rural counties, three urban counties, and New York City. This committee will work with DOH and DSS on policy issues regarding implementation, operation, evaluation, and modification of the project.
- o Other subcommittees will be established **as** necessary to allow for input and participation by the various stakeholders in the implementation and operationalization of the waiver program design.

B. Functional Responsibilities

Although DOH will have primary responsibility for the project, some of the functions will be shared with other entities. The following is a discussion of what agencies will be responsible for the **key functions** that need to be conducted under the proposed project:

- **Ratesetting** -- The Bureau of Financing and Contracting within the Division of Managed Care in DOH will be responsible for the development of the methodology for payment rate ranges for managed care managed care plans, including the partially-capitated plans. Payment rates for physician case management and **SNPs** will be developed in consultation with DSS and the responsible special needs agency.
- **Reinsurance** -- The Bureau of Financing and Contracting within the Division of **Managed** Care will develop and administer reinsurance for **all** capitated plans, including managed care plans, partially capitated plans, and **SNPs**.
- **Licensing/Certification** -- The Bureau of **Quality** Assurance and Utilization Review **will** provide for the certification and licensure of capitated plans. The AIDS Institute and **OMH** **will** help develop the licensing requirements for the AIDS **SNPs** and the mental health **SNPs**, respectively.
- **Contracting** -- The Bureau of Financing and Contracting will select qualifying plans by competitive bid in response to an **RFP**. The local **DSS** Commissioners will make the **final** selection of the plans to be placed under contract in their area. The local DSS Commissioners will sign contracts that have been approved by the Division with the plans.
- **Eligibility** -- DSS will be responsible for **establishing/revising** the standards, policies and procedures for determining eligibility and for assuring adherence to these by the local **DSS** offices. DSS will also be responsible for the design, development, and operation of the information systems necessary to support eligibility determination and verification.
- **Enrollment** -- The local **DSS** offices will be responsible for enrolling eligibles. However, DSS will be responsible for **establishing/revising** the policies and procedures for enrollment and for assuring adherence to these by the local DSS offices. The **Bureau** of Financing and Contracting will develop the auto-assignment algorithm.
- **Education/Outreach** -- The local **DSS** offices will be responsible for recipient education and outreach. However, OMH and the **AIDS** Institute will undertake an extensive outreach and education effort for the **SMI/SED** population and

HIV/AIDS population, respectively. Similarly OMRDD and OASAS will participate in the development and implementation of outreach programs to the developmentally disabled and substance abuse populations.

- **Capitation Payments --** Capitation payments **will** be made through the MMIS, which is operated and maintained by a vendor under contract to DSS.
- **Grievance and Appeals --** DSS will maintain the current system of fair hearings in accordance with federal requirements to hear appeals regarding eligibility for **Medical** Assistance or entitlement to benefits. The Bureau of **Financing** and Contracting in the Division of Managed Care will ensure that managed care plans have established appropriate grievance procedures and **will** provide a mechanism for appeals from those decisions.
- **Operational Reviews --** The Bureau of **Financing** and Contracting will oversee a team of personnel from various bureaus to conduct the initial health plan readiness reviews, any interim health plan reviews, and audits of health plans for compliance; **perform** on-site reviews; review reports from health plans; and conduct follow-up of their activities.
- **Data Validation --** The Bureau of Policy and Research **will** pull samples from encounter and other health plan reports and validate the data on-site using medical records and other sources of information to measure the quality, completeness, and accuracy of the **data**.
- **Quality Assurance/Utilization Review --** The Bureau for Quality Assurance and Utilization Review will be responsible for **assuring** the quality, necessity, and appropriateness of care provided by health plans. The bureau will review health plans' internal quality assurance programs, monitor health plans' provision of care; develop performance measures; develop practice **guidelines**; evaluate data from the health plans and from satisfaction surveys; and review utilization.
- **Data Analysis --** The Bureau of Policy and Research **will** conduct data analysis to support the State's planning and policy development.
- **Health Plan Reporting --** The Division of Managed Care, with DSS's advice and assistance, will determine what encounter data will be collected **from** managed care plans. DSS will be responsible for collecting the data **through** the **MMIS** and reporting such data to the Division. DOH and local DSS offices will ultimately have on-line access to this information and ad hoc reporting capability.
- **Federal Reporting --** In general, DSS, with cooperation from DOH, will be responsible for developing and submitting any federal reports. However, the

Bureau of Policy and Research within DOH **will** be responsible for compliance with the terms and conditions for approval of the waiver application.

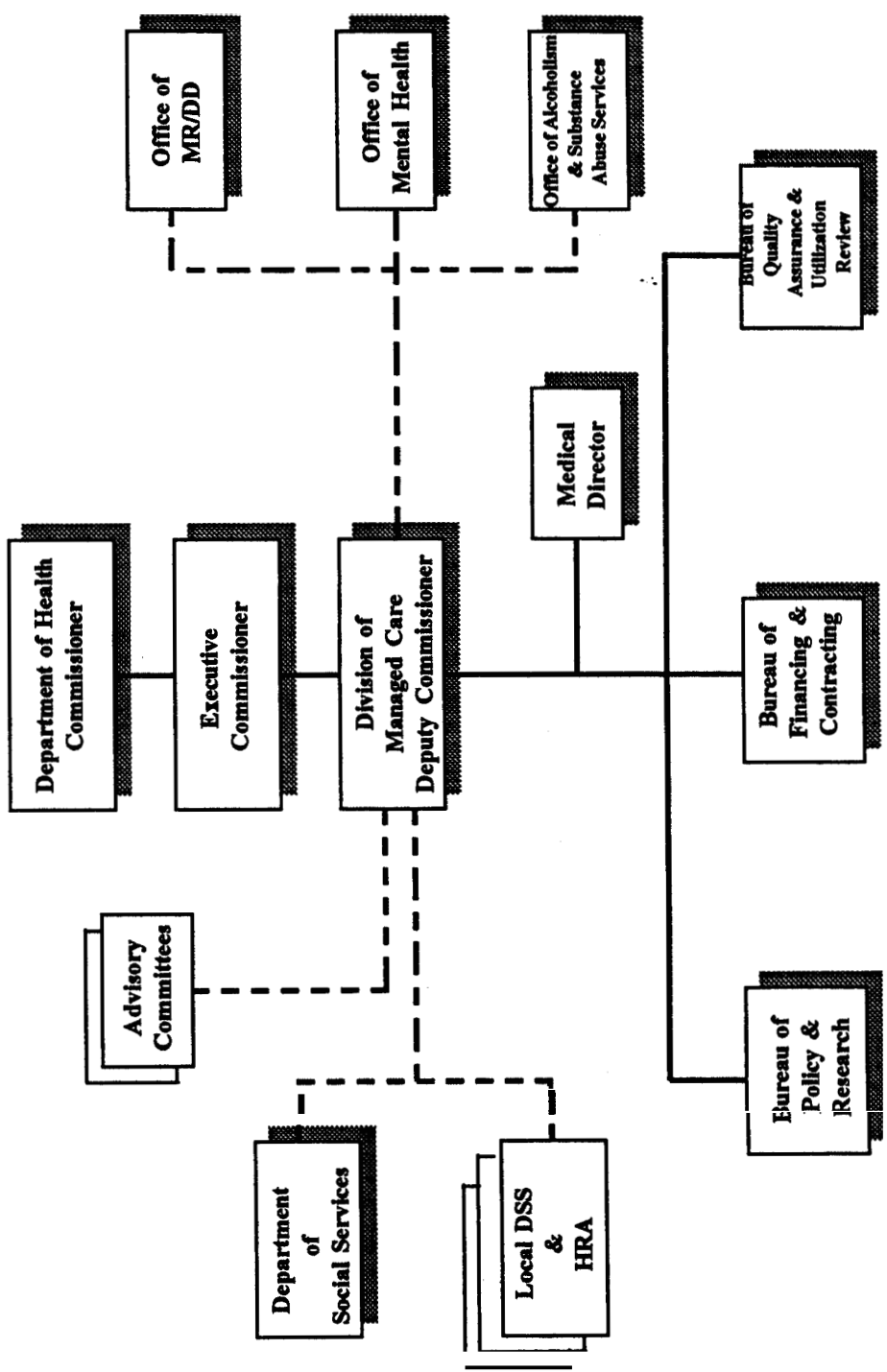
- **Policy** and Research -- The **Bureau** of **Policy** and Research in the Division of Managed Care **will** analyze major issues and problems in the demonstration project and formulate State policies regarding the project.
- Fraud and Abuse -- **DSS will** establish and implement policies and procedures to detect, investigate, deter, and prosecute fraud and abuse by managed care plans and providers . **DSS will** be responsible for determining any administrative penalty due from a provider because of fraud or abuse. **DOH will** be responsible for conducting administrative proceedings with respect to **a** managed care provider's license to determine whether the individual **will** be subject to discipline **as** a result of fraud or abuse.
- Third **Party** Liability (TPL) -- The managed care plans **will** be expected to pursue third party **liability** except for casualty, which **will** be **handled** by **DSS** .
- Budgeting and Forecasting-- The Bureau of Policy and Research **will** develop the program budgets, **study** trends, project **future** trends (for patterns of utilization, **growth**, cost of services, inflation, changes in service delivery, etc.), and monitor actuals.

In addition, some activities such **as** actuarial analysis, legal advice, technical assistance, and evaluation of the project **will** be conducted by contractors.

C. Timelines and Workplan

The following is a **Gantt** chart that provides an overview of the **timeline** for the demonstration project. A detailed workplan is attached **as** Appendix 4.

Exhibit 3.1
Proposed Organization



CHAPTER FOUR

EVALUATION

This chapter presents an evaluation plan for **New** York's proposed research and demonstration project. The State understands that HCFA will select an independent contractor to evaluate the demonstration project. Consequently, **this** chapter presents a framework for structuring an evaluation to **assess** the effectiveness of the demonstration's design and operations and to measure the outcomes in terms of policy-relevant objectives.

The Evaluation Chapter is organized into the following **sections**:

- A. Evaluation Objectives
- B. Relevant Policy Interests and Questions for Evaluation
- C. Data Sources
- D. Plan for Data Collection and Analysis

A. Evaluation Objectives

The New York demonstration **will** be implemented through mandatory enrollment of covered populations into prepaid health plans. The State recognizes that this delivery and financing model has been adopted by Medicaid programs throughout the country and **so** does not, in itself, represent a **sufficient** basis for innovative research.

However, the size and complexity of New York's proposed program distinguishes it from others already in existence and presents research opportunities not available to HCFA through any other state initiatives. The State believes that the body of research now available on Medicaid managed care is **useful** to state and federal policy makers in designing new programs but is **insufficient** in scope and breadth to fully assess the effects of alternative managed care models on the most vulnerable subpopulations of low-income enrollees. New York City in particular, with its cultural diversity and concentration of HIV+, mentally ill, and homeless populations, presents an exceptional opportunity for testing alternative managed care systems **within** a single program.

The project **will** expand eligibility for Medicaid services and enroll **most** eligibles in fully-capitated managed care plans offering comprehensive benefits and emphasizing primary care and preventive care. **Certain** individuals with special health needs because they are HIV+ and/or have **AIDS**, or who are severely and chronically mentally ill (SPMI adults and **SED** children) can be enrolled in innovative Special Needs Plans (SNPs). In addition, there are special provisions for the MR/DD, the homeless, and foster children.

In addition to a process analysis and documentary **case** study of the implementation and operation of the program, New York's demonstration offers unique research opportunities within three specific evaluation objectives:

1. To provide an enriched data base for Medicaid managed care evaluation and policy development, particularly for issues, aspects and subpopulations for which insufficient numbers and data are available within other states' programs;
2. To test innovative models of capitated managed care financing and service delivery for selected high-risk subpopulations, through specially designed Special Needs Plans; and
3. To assess the **effectiveness** of new approaches for program management and administrative models in a statewide managed care environment, including State/county relationships and responsibilities, and use of independent benefits counselors in the enrollment process.

B. Relevant Policy Interests and Questions for Evaluation

New York is keenly interested in the outcomes of the evaluation and hopes to use what is learned in the process **as** a basis for informing policy decisions regarding program expansion and health system reform over the long term.

I. *New York's Contribution to Informing Medicaid Managed Care Evaluation and Policy Development.*

The magnitude of New York's Medicaid managed care demonstration offers unprecedented evaluation opportunities by providing detailed data on large numbers of enrollees **within** a statewide program design. Specific **aspects** of Medicaid managed care and enrollee subgroups of particular policy interest, **as well as** within-plan member service and delivery interventions, can be isolated and thoroughly evaluated within the New York demonstration.

Although some conclusions can be drawn about specific aspects of Medicaid managed care and/or subgroups of enrollees through aggregation of multi-state data and experiences, the necessity of adjusting for inter-state **differences** in program policies and operational designs and political and budgetary influences invariably leave open questions about casual factors and cross-state replicability of models, impacts, and outcomes.

As described below, the New York demonstration will provide large amounts of data to support a within-state analysis of **key** Medicaid managed care issues in the key areas of policy interest to the federal and state governments.

Access to Quality Care for Health Status Improvements

As a result of improved access to coordinated care and the emphasis on preventive and primary services, demonstration participants are expected to exhibit better overall health status, particularly for pregnant women, children, persons with special health needs, and those who routinely experience **socio-cultural difficulties** in accessing services within a fragmented fee-for-service system.

Policy-relevant research questions appropriate for **framing** candidate hypotheses and structuring an intensive evaluation design, and which **can** be more **effectively** assessed with large numbers of enrollees within a single state managed care program, include:

- **Is** there an increased use of preventive and **primary services** among subpopulations of enrollees, with a related decrease **in**, e.g., inappropriate emergency room use, late prenatal care, and need for specialty services for prevention-sensitive conditions (such **as** pneumonia)?
- Do age-appropriate childhood immunization rates and adherence to periodicity schedules for **EPSDT** screenings improve? Are there statistically significant differences in these measures for subgroups of children, based on, e.g., age, ethnicity, health status, etc.? If **so**, what special outreach and/or access interventions might be effectively tailored to their special needs?
- **Is** there evidence of reductions in the incidence of preventable acute episodes and exacerbation of chronic health conditions among subgroups of the adult population who previously used an intensive level of services?
- How do key health status indicators change over time for different subpopulations participating in the demonstration?
- Are there statistically significant variations in key indicators of access to and use of primary and preventive services among different socio-cultural subgroups of enrollees? If **so**, can those differences be attributed to other factors (such **as** the type of plan model in which those subgroups are enrolled), or do they clearly indicate the need for more culturally-sensitive outreach, member services, **and/or** service delivery interventions?
- Among subgroups of eligibles who previously evidenced **difficulties** accessing the fee-for-service system (such **as** the homeless, persons with language or other cultural barriers, or persons with a history of inappropriate emergency room use), does a comprehensive managed care program and creation of a “medical home” for all eligibles improve their ability to access and prudently use services?

- Among the homeless and the Home Relief populations, what are the characteristics of those who do, and do not, effectively select, enroll in, and use a managed care plan? What types of plans do they choose, and what special outreach, member services, and service delivery interventions are most effective in improving access and health status for these populations? Is there evidence of pent-up demand or need for primary and preventive services, and what, specifically, is the nature of their priority **unmet** health service needs?
- **Is** there a significant increase in physicians' participation in Medicaid compared to the pre-demonstration period, among primary care and specialty physicians within **small** geographic areas and among those of different cultural or linguistic competencies?
- What are the differences in enrollee primary care physician (PCP) ratios among the different health plans, and are those differences correlated with variations in **key** indicators of access to and appropriate use of primary and preventive services?
- Are there significant variations in access and outcomes measures among health plans with a larger percentage of PCPs who are some way more, or less, "indigenous" to the plan's enrollee population **in, e.g.,** cultural mix, multi-linguistic abilities, or **as** providers who reside within the community being served?
- In what ways have individual health plans developed and implemented outreach, member services, **and/or** service delivery interventions tailored to the characteristics of their enrollee populations? Among those interventions, which models appear to be most effective in increasing access to primary and preventive services, or otherwise improving member satisfaction and health outcomes? What types of health plans are more proactive and creative at developing such interventions?
- Similarly, to what extent and in what ways have the different health plans established effective "**partnership**" arrangements with community-based social service agencies and resources and/or local advocacy organizations, tailored to the special needs of subgroups of their enrollee populations? Which types of such liaisons appear particularly effective?
- **To** what extent is inclusion of traditional providers (**e.g.,** high-volume Medicaid physicians, community clinics and **FQHCs**, etc.) in the health plans' network indicative of and a positive factor **in,** the plan's ability to serve its enrollee populations in socio-culturally sensitive ways?
- Are there statistically significant variations in member satisfaction and key indicators of access and health outcomes among enrollees in more

“mainstream” type health plans (i.e., plans designed and operated primarily to serve a commercial population), compared to more “tailored” health plans, (such **as** those sponsored by, or with a large network composition **of**, traditional Medicaid providers, or which are designed primarily to serve a low-income population)?

Cost-Effectiveness of Managed Care

New York shares the interest of the federal government and **all** other states in determining the extent to which, and in what ways, Medicaid managed care *can* result in more cost-effective provision of services to low-income populations. **As** with all 1115 demonstrations, the overall **costs** and savings generated by the demonstration will be assessed through ongoing monitoring and the demonstration’s performance against the budget neutrality projections. In addition, there are a number of more specific cost-effectiveness questions **that** are not likely to surface **through** routine financial monitoring, and which cannot be reliably assessed in **smaller-scope** statewide managed care initiatives, but which merit particular attention in the evaluation. For example:

- How do the projections of cost and savings in the budget neutrality framework break out for discrete geographic areas, among different types of health plans, for subgroups of enrollees, etc.? Where are significant savings and **costs** most evident, and how are costs or savings in one **aspect/area** of the program compensated for in others?
- Do costs per enrollee vary significantly among different settings (such **as** communities within the New York City urban area) and among different types of health plans with similar enrollee case-mix?
- Are such variations in per capita costs evident within subgroups of enrollees, such as the HIV+, mental health, substance abuse, etc. groups?
- Are there significant variations in per capita **costs** for selected types of services or episodes of care for selected diagnoses, and do those variations change in a managed care environment compared to, e.g., geographic variations in practice costs under a fee-for-service **system**?
- How do health service expenditure patterns change for selected diagnoses? **Is** there, e.g., a more observable shift to primary and preventive care (from specialty and inpatient services) for some diagnostic categories than for others?

Public Policy, Planning and Program Development

Medicaid managed care is widely perceived to offer a valuable framework for program planning and development, **as** an infrastructure for larger health system reforms. And Medicaid managed care also serves **as** a vehicle for improving states’ abilities to manage

the growth and predictability of Medicaid **costs** within their overall state budgetary processes.

The scope and **cost** of New York's Medicaid program, and the needs of its diverse low-income population, present remarkable challenges for policy development, program planning and budget management. **As** such, New York represents the most revealing "laboratory" for exploring the potential of Medicaid managed care to improve states' capabilities in program planning and development and in budget management.

- What impact does statewide mandatory managed care have on New York's **ability** to effectively plan and pursue program development and reform, in both the short and long term?
- **To** what extent does the managed care initiative improve New York's ability to **accurately** project, and prepare for, budgetary needs of maintaining health services for its low-income residents?
- How **has** the State used the data generated from a statewide managed care **system** for more relevant and effective program analysis and planning?
- How **has** the State redirected its priorities, resources and responsibilities in overall and ongoing planning, policy-making and budget management, in response to the different needs and challenges of a managed care system?

2. *Managed Care for Special Needs Populations – New Models and Research Opportunities*

The New York demonstration incorporates innovative approaches and managed care models designed to improve access and service delivery specifically for vulnerable populations of eligibles who have special needs because they are HIV+ or have **AIDS**, or are chronically mentally ill (the **SPMI** and **SED** populations), and for subgroups of those populations who need intensive substance abuse **services**.

Many states have **experienced** particular difficulty in designing managed care models and financing arrangements to **meet** the needs of these populations. And many States have also encountered resistance to enrollment of these special populations in managed care, especially when the state's managed care initiative is largely reliant on contracting with "mainstream" managed care plans. A **variety** of approaches **has** emerged, but most involve subcapitated arrangements between a "mainstream" health plan and traditional providers, within the same general construct as contractual arrangements with other network providers, albeit with more complex and sensitive challenges.

New York is prepared to explore the potential for more creative and innovative approaches, involving opportunities for providers who traditionally serve these populations to establish more autonomous, needs-sensitive managed care arrangements,

for “mainstream” health plans to establish different **types** of **referral** and financing arrangements with such Special **Needs** Plans, and for persons with special needs to exercise choices among alternative managed care arrangements.

Some of the relevant research questions include:

- Does the availability of **SNPs** improve **access** to care for SNP-eligible enrollees, and/or their receptivity to and satisfaction with service delivery within a managed **care** environment?
- e Does the type of intensive needs-tailored benefit package and service delivery approach of a **SNP** improve the overall health status of **SNP** enrollees, such as delayed **onset** of **AIDS** among HIV+ enrollees, and/or fewer acute episodes among the chronically mentally ill?
- e Does enrollment in a **SNP** **significantly** reduce the incidence of emergency room use (for both emergency and non-emergency conditions) among **SNP** enrollees, compared to their emergency room use rates in a fee-for-service system, and compared to clinically comparable enrollees in “mainstream” health plans?
- Does the use of **SNPs** reduce the rate of institutionalization among mentally ill and/or HIV+/AIDS SNP enrollees? **Do SNPs** provide or foster alternatives to institutionalization for their enrollees? What models are particularly effective, and are they replicable in a “mainstream” **managed** care plan or in a fee-for-service setting?
- e Do **SNP** enrollees experience lower rates of reinstitutionalization than clinically comparable enrollees of “mainstream” health plans or those in a fee-for-service setting?
- **Overall**, what differences in the settings of service delivery are evident in SNP models? **Is** there more emphasis on community- and home-based, ambulatory and outpatient care?
- How do rates of referrals to specialists change for **SNP** enrollees, compared to their pre-demonstration experience and to comparable enrollees in “mainstream” plans?
- e What are the **health/functional status** and demographic characteristics of SNP-eligible clients who do, and do not, choose to receive services in a **SNP**?
- e Among SNP-eligible clients with multiple needs (such as those who are mentally ill and HIV+ and/or substance abusers), what choices do they make among alternative managed care models? How well do **SNPs** meet the

multiple needs of such enrollees, compared to “mainstream” managed care plans?

- How are the needs of enrollees in methadone maintenance programs met through “mainstream” managed care plans compared to **SNPs**? There are about **40,000** methadone maintenance patients in New York City, two-thirds of whom are **SPMI** or **HIV+** (or both). Many of these clients today rely on their methadone maintenance clinics as a **source** of primary care services. **How** is service access and use, and health outcomes, **affected** as these individuals become enrolled in “mainstream” plans, or in **SNPs**? To what extent and in what ways do the methadone maintenance clinics participate as providers in either type of managed care arrangement, with **what** different impacts on the clients and on the clinics’ **ability** to serve non-demonstration participants?
- What other differences in provider network composition, and satisfaction among network providers, exist among alternative health plan models, at the outset and over time? In particular, do “mainstream” plans and **SNPs** rely on the same cadre of specialists?
- Are **SNPs** more proactive and creative in establishing “partnerships” with community-based social service providers and indigenous resources for service delivery and member services?
- How do **SNPs** and “mainstream” managed care plans establish mechanisms for coordination of care, and transition of enrollees who are referred to and enroll in **SNPs**? What types of ongoing relationships are established among the plans’ primary care providers and speciality services? How are medical records maintained and clinical information exchanged?
- How are criteria of need for **SNP** services defined, applied and coordinated among the health plans?
- How does the referral and transfer process work among the “mainstream” plans and the **SNPs**? How many months do “mainstream” plans retain enrollees who are subsequently determined to qualify for **SNP** services and/or until the health plan initiates a referral arrangement with the **SNP**? Over time, do the health plans become more adept at identifying clients for whom referral to a **SNP** would be advisable?
- What is the minimum number of enrollees for each type of **SNP** to be financially viable and to manage the risk inherent in serving these populations? What type of risk management strategies do they develop? To what extent can and do **SNPs** extend their service areas beyond densely populated urban centers, and what mechanisms do they develop to serve a more sparsely populated area?

- How well do **SNPs** perform, financially, over time, and how do they evolve? Do **SNPs** become a vehicle for traditional providers to develop capabilities as full-service managed care plans, or do they become increasingly specialized?
- How do alternative models of **SNPs** compare on the above evaluation measures?
- Does the **SNP** model (or variations of it) prove to be more successful and effective depending on the needs of the population being served, i.e., are mental health-oriented **SNPs** more or less viable than those developed for **HIV+/AIDS** enrollees? What “lessons learned” are relevant to any **SNP**, as opposed to experiences and models specific to particular populations?
- What does the New York demonstration experience with **SNPs** reveal about the prospects for development of **SNPs** for additional subgroups of enrollees, such as those with mental retardation/developmental disabilities?
- How does the existence of **SNPs** influence the extent to which “mainstream” managed care plans develop special service delivery approaches for their own “special needs” enrollees? Do “mainstream” plans become even more “mainstream,” or do they evidence an increased emphasis on tailoring their services to other special needs enrollee subgroups for whom there are not “SNPs” (like pregnant teenagers), or do they attempt to compete with **SNPs** by duplicating the **SNP** needs-sensitive models?

3. *Evaluation of Alternative Program Management and Administrative Models*

Every state’s Medicaid managed care initiative will necessarily be grounded in, and influenced by, organizational and administrative characteristics unique to that state’s program. The New York demonstration, however, offers an opportunity to surface “lessons learned” about two aspects of managing Medicaid managed care that are of broader federal and state interest:

- The challenge of achieving a balance between statewide uniformity and local needs for flexibility and autonomy, in managed care model design and program administration; and
- The various issues relevant to the decisions of whether to use an independent entity for enrollment and plan selection, and how best to structure such arrangements.

Innovations and Issues in State and Local Program Design and Governance

Like several other states, New York State's Medicaid program **has** evolved within a framework **of shared** responsibility between state and county-level governments. Implementation of statewide **managed** care creates a new arena, with new challenges and opportunities, to revisit and redefine a state/local relationship in program design and administration. Many states are **confronting** similar issues, and, in fact, the challenge of creating **a** mutually satisfactory balance between centralized control and local flexibility remains evident in federal-state relationships **as** well.

In the New York demonstration, local districts **will** have flexibility to design and/or operate the new Medicaid managed care program in a variety of ways, each of which raises interesting questions **about** the choices made by local governments, the reasons for these choices, how such **variability** will work in practice, **and** the impact it will have on the overall effectiveness of the statewide program **and** the individual enrollees it serves.

Examples of opportunities that **will** be available **to** local social services districts to tailor **a** managed care program that best fits the needs of the local population include:

- *Local districts will execute contracts with health plans selected by those districts from a list of State-approved organizations.* How do local districts exercise this flexibility, and what different factors do individual **districts** consider in selecting health plans to serve their communities? When all the contracts have been awarded, are there observable differences in the array of plan models among the local districts, **and** are those differences reflective of socio-economic, demographic, or other differences among districts?
- *Local districts working singly or in conjunction with neighboring districts can select their model of mental health Special Needs Plan(s).* How much variation in mental health **SNP** models results **from this** flexibility? **To** what extent do local districts themselves take the initiative to shape or choose among alternative models? **Do** local districts **successfully** collaborate to implement multi-district regional **SNPs**, and are those models more viable than smaller-scope, locally confined models?
- e *Local districts will determine whether to retain school-based clinics in the Medicaid fee-for-service system with a block grant from the State or whether to encourage the clinics to immediately align themselves with capitated managed care plans.* Variation among school-based clinics exists within any state's program, in terms of the **scope** of services they provide and the extent to which they are **used** by the local population of low-income children **as** a primary source of care. Does **allowing** local governments **to** determine how clinics **will**, or will not, be integrated into Medicaid managed care result in better, more local needs-sensitive arrangements?

- *Rural districts where managed care will be offered through partially capitated plans may arrange for provision of (fee-for-service) non-emergency transportation through designated providers.* How do those arrangements compare to non-emergency transportation services provided **through** fully capitated plans, in **assuring access** to services for geographically isolated recipients? What types of selection criteria, processes, and providers are established under such arrangements? Over time, do partially capitated plans pursue relationships with designated transportation providers leading to the incorporation of those providers within the plans' networks and capitated benefit packages?
- *Rural districts that have partially capitated plans that do not provide pharmacy benefits may establish mail order arrangements for provision of (fee-for-service) prescription drugs.* How do utilization patterns, and satisfaction with **access** to prescription drugs compare among recipients who receive their pharmacy services within a **fully** capitated managed care plan versus those who use a mail-order service? How is care coordinated between the mail-order pharmacy providers and the partially capitated plans? Over time, **as** acceptance and use of mail-order pharmacy services becomes well established in the **community**, do the partially capitated plans pursue expansion of their benefit packages to include prescription drugs?
- *Local districts will be responsible for eligibility determination and the process of enrollment of eligibles into managed care plans, including the decision of whether to use an independent entity for enrollment and plan selection.* Within the basic research interest in comparing alternative approaches developed by the local **districts**, the opportunity will exist to thoroughly evaluate a number of issues and questions relevant to the use of "Benefits Counseling" contracting, **as** presented in detail below.

Making **Informed** Choices – Evaluating Benefits Counseling Models

State Medicaid managed care programs **can** either incorporate special mechanisms to help eligibles make **informed** choices among managed care plans, or they can implement a more "mainstream" model, leaving it to the health plans and the clients to interrelate with each other, with or without rigorous state-imposed constraints on health plan marketing practices.

In New York, while ~~direct~~ marketing by health plans will be prohibited, each local district may decide whether to contract with an independent, unbiased entity to assist eligibles with plan selection and enrollment. Various issues of interest to many states emerge in deciding whether to use such "Benefits Counseling" contractors, and in structuring the scope and nature of the contractor's responsibilities. For example, the evaluator would have the opportunity to **assess** issues and questions such **as**:

- Are there fewer auto-assigned cases in districts where there is a Benefits Counseling contractor?
- Does a Benefits Counselor's **assistance** in choosing a health plan improve the enrollees' satisfaction with that plan -- do they stay with their selected plan longer, and like it better, than enrollees whose **choice** was made without such assistance?
- Should Benefits Counselors also do outreach, provide general orientation to help new enrollees to adapt to a **managed** care environment, select and establish a good relationship with a primary care physician, etc. -- **i.e.**, what scope **of** responsibilities is most cost-effective for such contractors?
- How do Benefits Counselors ~~interrelate with~~ State and local entities and with managed care plans, for exchange of routine data and in handling cases that need special attention?
- **Will** Benefits Counselors inevitably become, or perceived themselves to be, client advocates? Should they also serve in an ombudsman function? Should Benefits Counselors assist enrollees, or represent them, in pursuing complaints within the health plans' grievance systems?
- How should Benefits Counselors deal with client legal or **safety** issues that will come to their attention, such **as** signs of domestic violence, drug abuse, homelessness, urgent medical needs, **etc.**?
- What should the contracting entity look for in selecting a Benefits Counseling contractor? What models, skills and resources are essential to effective performance? How should costs of such contracts be evaluated?
- What data needs to be collected by, and shared among, the State, the local district, the Benefits Counselor, and the health plans, and what systems reconfigurations are needed to accommodate such arrangements?

C. Data Sources

The data to be used in the evaluation of the demonstration project will be derived **from** several sources, including existing data sources, encounter data collected from the health plans, and data sources developed **specifically** for the demonstration. The evaluator may identify other data needs **as** the study design is **finalized**, and the State will make every effort to facilitate access to necessary data. It is of course **critical** that data collection begin very early in the implementation process to ensure an adequate baseline for comparison of the pre- and post-implementation experience. The potential data sources include:

1. Case Study Interviews
2. Per Capita Data
3. Member Satisfaction **Surveys**
4. Member Grievances and Appeals
5. Medical Records Analysis Samples
6. Health Plan and Provider **Surveys**
7. Data from Ongoing Project Monitoring, including Expenditure Reports and Encounter Data

1. Case Study Interviews

To supplement HCFA's monitoring of the core aspects of implementation and operations, case study interviews would be useful in evaluation of the planning and implementation of the demonstration. These interviews would provide information on the program processes and help in validating and understanding the quantitative results. **Key** persons that should be interviewed include:

- Staff from DSS, **DOH**, legislative staff, and other State agencies and **community** service organizations that have contact **with** project members
- Representatives and administrators of participating **and** nonparticipating health **plans**
- The Medical Advisory Commission
- Provider associations and other provider groups
- Advocacy and citizen/consumer groups

The issues **that** could be addressed in these case study interviews include:

- Program awareness and expectations
- Perceived Quality of care (satisfaction overall, access, and responsiveness)

- Comparison to health care delivery prior to the project
- Reasons for policy and operational decisions on the part of the State as well as among providers and plans
- Changes in operations needed to accommodate the demonstration project
- Factors influencing plan formation (e.g., geographic variations in program structure, rates, etc.)
- Factors of the program influencing the health plans' delivery system (e.g., ability of plans to attract specialists in rural areas)
- Effectiveness of outreach and enrollment strategies

2. *Per Capita Data*

Because the proposed demonstration project is designed to improve access, quality, cost-effectiveness, and appropriate utilization of services, ongoing per capita encounter and expenditure data is necessary. The evaluator could use this data to determine whether the project is indeed slowing the increase in costs, encouraging appropriate utilization of services, and improving access to quality care. The three primary sources of per capita information will be:

- Medicaid claims data from the State MMIS
- A Demonstration Data Set of person-specific encounter data from the health plans
- Eligibility and Enrollment Data from the State's eligibility system and MMIS

State Medicaid Management Information System (MMIS)

The MMIS, which processes the current fee-for-service Medicaid program, is able to produce historical, per capita utilization and cost data. In addition, fee-for-service utilization and expenditure data can be obtained and summarized for each eligible group (e.g., AFDC children). Initially, this information will be used to set confidential capitation ranges. Ultimately, the historical fee-for-service data could be used for comparison with encounter data from the health plans to determine increased/decreased utilization, service delivery changes, and to support costs/savings analysis.

Demonstration Data Set

Health plans will not be required to submit individual pseudo claims to the State. Instead, New York will require the health plans to provide encounter information that identifies what services a consumer received, by what provider, and by date of service with diagnosis and procedure codes. A minimum **data set** will be defined to ensure appropriate data is captured to make comparisons throughout the demonstration. Health plans will be required to submit that data via electronic media on a quarterly basis consistent with the format specified by New York. The demonstration data **set** includes encounters for each of the following types of service:

- Professional Service
- Dental
- Transportation
- Vision
- Inpatient
- Outpatient
- Home Health
- Drug

The State will develop **similar** encounter reporting requirements for the *SNPs*.

Eligibility and Enrollment Data

Eligibility and enrollment information is **maintained** in New York's eligibility system and in the **MMIS**. **This** information will be available to calculate member months by eligibility category, age, sex, location, plan enrollment **status**, and rate code for various periods.

3. Member Satisfaction Surveys

Member satisfaction **surveys** will be administered to samples of the demonstration participants to evaluate **their** satisfaction with the project and the health plans. The survey will also provide information on other project outcomes, such **as** changes in the participants' health status, out-of-pocket expenditures for **health** care, utilization, and access. **This** information will also be **useful** for the quality assurance program. In addition to the **surveys** that the health plans must administer, the State will develop **surveys** that will be administered annually to a statistically valid random sample of clients. Over time, a standardized **survey** will be developed, preferably to be computer-generated **so** the data

can be read by scanner and automatically recorded and tallied. The **survey** questions will address the following areas:

- Enrollment process
 - Entry into the project/health plan (enrollment process)
 - Maintenance of eligibility (re-certification)
 - Eligibility problem resolution
 - Disenrollment process
- Satisfaction with health plan
 - **Overall** satisfaction with health plan
 - Satisfaction with primary care physician (PCP)
 - Satisfaction with specialty physicians, prenatal physicians, surgeons, and other physicians
 - Access to emergency, urgent, routine, and preventive care
 - Services available for getting prescriptions filled
 - Convenience (travel time and hours that the office is open)
 - Availability of medical advice by phone
 - Difficulty in obtaining services
 - Responsiveness in non-emergency visits (measured in waiting time with and without appointment)
 - Availability of specialty care (wait time and convenience)
 - Patient rapport and confidence
 - Treatment by non-medical support personnel (courtesy, respect, and **support**)
 - Treatment by medical support personnel (courtesy, respect, and **support**)
 - Communication (explanation of procedures and tests; attention to what the member **has** to say; advice about staying healthy)
 - Grievances handled quickly and **fairly**
 - Health plan requirements and procedures (availability of information; complicated or difficult **to** understand)
 - Satisfaction with choice (number of doctors to choose from)
 - Referral problems
- **Quality** and Outcomes
 - Perceived quality of care and services
 - How well care meets the member's needs

- Health Status/Utilization

- Current health **status** (self-reported)
- Health behaviors (~~smoking, drinking~~, activity, etc.)
- Any health care visits (type and number of visits)
- Any new health care needs detected (number of ~~diagnoses~~/episodes)
- Any emergency utilization (number of visits)
- Any hospital inpatient days (number of days)

Surveys will be conducted annually. A sample of current Medicaid eligibles will be surveyed at the beginning of the demonstration to obtain ~~baseline~~ information to provide a comparison ~~between~~ the current programs and the demonstration project. Newly eligible participants will complete the survey when they ~~first~~ apply to **allow** for comparisons of pre- and post-enrollment utilization levels. Thereafter, surveys of current and new members will be conducted periodically throughout the ~~life~~ of the demonstration.

4. *Member Grievances and Appeals*

Health plans will be required to establish grievance procedures for members, and members ~~will~~ have the same appeal rights **as** traditional Medicaid eligibles; **i.e.**, they will have access to the State's hearing system, which meets the requirements of 42 CFR ~~Part 431~~, Subpart E. However, members with a grievance against a health plan ~~must~~ have exhausted the health plan's grievance system. General and plan-specific problems **will** be identified by collecting information regarding grievances brought in either venue and analyzing the bases for the grievances, how they were resolved, and the timeliness of the process.

5. *Medical Records ~~Analysis~~ Samples*

The evaluator should ~~analyze~~ a statistically valid sample of patient medical records to assess the demonstration's impact on the health status of subgroups of participants and to evaluate the type, quality, and appropriateness of care provided in the project. The analysis would consist of evaluating the changes in health status on the basis of medical record documentation of ~~encounters~~, including but not limited to preventive services, diagnoses (provisional, admitting, ~~working~~, and discharge diagnoses), treatment, referrals, and outcomes. **This** analysis would also be useful in supplementing and confirming self-reported health **status**.

6. *Health Plan and Provider Surveys*

The evaluator should survey participating health plans and ~~affiliated~~ providers to assess their satisfaction with the demonstration and to ~~identify~~ factors which led the health plans and providers to participate. The surveys could **also** be used to obtain information on any changes that the health plans may have implemented to comply with project requirements or to facilitate their **taking** on **this** population. The surveys could assess such factors as altered reimbursement structure, operating environment, marketing, or an increased need

for educational or outreach efforts. Before the **start** of the demonstration project, the evaluator should **survey** the health plan and providers to establish an initial benchmark. Thereafter, surveys could be conducted at intervals throughout the demonstration. The surveys could focus on the following **areas**:

- o For the **health** plans
 - Cost effectiveness of project design
 - Quality of care **accountability**
 - Business **performance**
 - Potential for further **cost** containment
 - Evidence of **cost** shifting
 - Special member services or service **delivery** **interventions** developed to serve the needs of the Medicaid population
- For the service providers
 - Satisfaction with project design
 - Quality of **care/professional** latitude
 - Satisfaction with and any changes to the **referral** system
 - Satisfaction with and any changes to utilization management
 - Potential for improving or expanding project
 - Incentives to become involved or remain in the project
 - Perceived health status of patients
 - Number of patients **seen** and number of visits
- Factors **affecting** decision **to** participate
 - Benefit package
 - Capitation rate
 - **Length of contract**
 - Potential increase in patient volume
 - Demonstration administration and reporting requirements
 - Potential reduction in amount of uncompensated care

7. *Data from Ongoing Project Monitoring*

As described in Chapter **Two**, data will be collected from the participating health plans throughout the course of the demonstration project. **This data** will be used to augment the information obtained through other data collection methods.

D. Plan for Data Collection and Analysis

Throughout the evaluation, the challenge **will** be to obtain complete, accurate and meaningful data. Initially, differences in data collection and reporting capacities among plans and providers **will** have to be addressed. Data collection and reporting according to project standards that are documented and made available to the plans **will** remain a **high** priority in oversight of the managed care plans.

The State has established a standard demonstration data set in connection with reporting requirements. **This** data **set will** be revised and expanded in order to apply **to** reflect the special aspects of monitoring and evaluating services to person enrolled in *SNPs*, such as HIV/AIDS and mental health clients. Data elements **will** be well defined in order to eliminate classification and reporting difficulties at the **provider and** health plan levels. The evaluator and the State **will** establish rules for aggregating and collapsing data into required elements.

The evaluator could use the following suggested methodologies to test the research hypotheses using the data **sources** listed above:

- Case studies and **surveys** of health plans, providers, and members
- Comparisons of key aspects of the project based on geography, participating health plans, and selected populations
- Cross-state comparisons to determine how New York's demonstration experience has changed the nature of New York's Medicaid program relative to other states' Medicaid programs
- Impacts on new Medicaid eligibles through the development of baseline data at the **time** of initial enrollment and subsequent demonstration data
- Impacts on subgroups of current eligibles, focusing on changes over time and variations in impacts across and within subgroups of eligibles.

The development of appropriate baseline data to support the evaluation is likely to require collection of baseline data specific to:

- Each participating health plan
- Individual counties
- Selected types of service diagnoses
- Eligibility and demographic subgroups

The evaluator could measure quality of care and health **status** primarily through analyses of consumer surveys and medical records. **This** would entail pre/post comparisons of consumer responses to questions regarding quality of care and health **status**, supplemented by medical record **analysis**. Specific "tracer conditions" could be selected and followed through medical record review to assess changes in health **status**. In addition, the quality assurance system should provide data **sources** for **this** analysis, including standard quality indicators and **functional** outcomes.

Pre/post comparisons of **consumer** survey responses could be used to assess the demonstration's impact on access to, and availability of, care. **MMIS** and provider survey data could be used to evaluate the availability of care in terms of the distribution of various types of providers participating in the project. Consumer survey data, supplemented by medical records review, would provide the **basis** for measuring changes in the usual source of care, which would enable the evaluator to assess continuity of care.

Project expenditures could be analyzed through a **series** of comparative analyses using expenditure data from the **MMIS** and data collected during monitoring of the demonstration. The evaluator would also make comparisons of the changes in service expenditures by eligibility and demographic group using per capita data. The evaluator could supplement these analyses with case studies and health plan, provider, and consumer surveys.

The evaluator could measure the impact of the project on **services** utilization via surveys, MMIS data, eligibility files, and provider **files**, supplemented by data regarding utilization **from** ongoing project monitoring.

CHAPTER SIX

WAIVERS REQUESTED

New York requests the following waivers of statutory and regulatory requirements in order to implement the Medicaid Managed Care Demonstration Project.

A. Waivers Under Section 1115(a)(1)

Statewide

Section 1902(a)(1) of the Act and 42 C.F.R. § 431.50 require that the state Medicaid plan be in effect for all services and all eligible recipients in all political subdivisions of the State. The type and selection of managed care plans available under the demonstration may vary by geographical area of the State (i.e., fully capitated **HMOs** and PHSPs, transitional partially capitated plans), although the benefits offered **will** be the same. Moreover, the fee-for-service population (i.e., persons in long term residential institutions, the Medicare/Medicaid dually eligible) **will** receive benefits in a different manner than the Demonstration Project participants. The Demonstration Project **will** also allow local social services districts to designate a provider for non-emergency transportation or to allow Medicaid recipients to purchase drugs through a mail order provider. New York therefore requests that these provisions be waived.

Comparability of Services and Eligibility

Section 1902(a)(10)(B) of the Social Security Act ("Act") and 42 C.F.R. § 440.230-250 require that the amount, duration, and scope of services be equally available to all recipients within an eligibility category, and **also** be equally available to categorically eligible recipients and medically needy recipients. The Demonstration Project will mandate that certain groups of Medicaid eligibles enroll in managed care plans and will also make available Special Needs Plans to individuals with certain diagnoses. However, other groups of Medicaid eligibles will be excluded from the Demonstration Project and will not be enrolled in managed care plans. A third group **will** be allowed to enroll voluntarily. Some of these groupings cut across eligibility categories. Moreover, until fully-capitated plans are available statewide, benefits may be administered differently depending on the county in which a recipient lives. The Demonstration Project will also allow local social services districts to designate a provider for non-emergency transportation or to allow Medicaid recipients to purchase drugs through a mail order provider. Finally, only categorically eligible recipients will receive wrap-around alcohol and substance abuse services, **as** delineated in the current state plan, once those services in the basic benefit package have been exhausted. In order to account for any differences in amount, duration, or scope of services for recipients who will be enrolled in managed care as opposed to the fee-for-service plan, New York requests that these provisions be waived.

Eligibility Standards

Section 1902(a)(10)(A)(i) and 42 C.F.R. ~~Part~~ 435 requires States to provide medical assistance to certain categories of individuals including those either receiving or deemed to be receiving medical assistance on the basis of certain welfare categories under the Social Security Act. New York requests a waiver of section 1902(a)(10)(A)(i) and the implementing regulations in order to extend coverage to individuals receiving Home Relief cash assistance. New York also requests a waiver of these provisions to allow it to extend eligibility for family planning services only to pregnant women for 24 months post-partum.

Financial Responsibility

Sections 1902(a)(10) and 1902(a)(17)(D) of the Act and 42 C.F.R. Part 435 establish standards for taking into account income or resources of individuals who are not receiving assistance under **AFDC** or **SSI**. The State ~~seeks~~ a waiver of ~~these~~ to the extent necessary to extend eligibility to individuals receiving Home Relief and to pregnant women post-partum.

Federally Qualified Health Centers

Section 1902(a)(10) and 1902(a)(13)(E) of the Act require that Federally Qualified Health Centers (FQHCs) be reimbursed on a reasonable cost basis. The State will no longer guarantee FQHCs 100% of their **incurred costs**. Many, if not **all**, FQHCs will be part of managed care plans and will be paid by health plans out of the capitation rate. To the extent this requires a waiver of Section 1902(a)(10) and 1902(a)(13)(E), the State requests such a waiver.

Retroactive Coverage

Section 1902(a)(34) and 42 C.F.R. § 435.914 requires States to retroactively provide medical assistance for three months prior to the date the application for such assistance is made. New York seeks a waiver of these provisions with respect to the Home Relief population.

Freedom of Choice

Section 1902(a)(23) of the Act and 42 C.F.R. § 431.51 require a state plan to pay for medical assistance from any institution, agency, community, pharmacy, or person qualified to perform the service or services. The demonstration will allow participants to choose among available plans and practitioners every year, but will restrict each participant to a single health plan or practitioner that will render or arrange for **all** or most care for the one-year period, except that a participant may change plans for cause. **Also**, it is not unlikely that there will be only **a** single **HIV/AIDS** or Mental Health Special Needs Plan in operation in any given area. To the extent any of this is seen **as** a limitation on freedom of choice, a waiver is appropriate and necessary. There will be no restriction of freedom-of-choice for family planning or emergency services. A waiver of this section is **also** requested **so** that eligibles not enrolled in managed care plans because they will be eligible for less than **6** months (e.g., seasonal agricultural workers) may be assigned to a clinic **as** a gatekeeper for their health care needs.

Third Party Liability

Section 1902(a)(25) of the Act and 42 C.F.R. ~~Part~~ 433 require that the State identify liability of and seek reimbursement from third parties before paying claims. The State requests a waiver from specific requirements established under these sections since the demonstration project **will** pursue alternative ways to handle third party liability. Casualty claims will continue to be pursued by the State. Non-casualty third party resources will be pursued by managed care plans. The State **will** reduce all capitation rates by an actuarially appropriate amount, based on the State's own experience, to reflect the average amount of funds that can be recovered from third parties.

Guaranteed Eligibility

Section 1902(e)(25) of the Act provides that six-month eligibility can be guaranteed only for individuals enrolled in federally qualified and certain other HMOs specified in subsections (2)(b)(iii), (2)(E), (2)(G) and (6) of Section 1903(m). The State is requesting a waiver of this section **so** that it might offer guaranteed eligibility for the ~~first~~ **s** i months to **all** managed care enrollees regardless of which type of provider the individual is enrolled in.

Upper Payment Limits

Sections 1902(a)(30) of the Act, **as** implemented in the upper limit regulations at 42 CFR §§ 44.423(b), 44.7361, and 44.7362 establishes upper payment limits for capitation contracts. The State seeks a waiver of these provisions to enable it to arrange or negotiate payment rates without the need to develop contract-specific upper payment limits.

Disproportionate Share Hospital Payments

Section 1902(a)(13)(A) of the Act, which also incorporates Section 1923(c)(1), requires a State to pay to hospitals that serve a disproportionate share of low-income patients a payment adjustments equal to or in excess of the Medicare minimum. The State requests a waiver of ~~this~~ section insofar **as** payments **to** disproportionate share hospitals will take the **form** of supplemental payments under the waiver. This is a technical waiver, as these supplemental payments **will** equal or exceed the Medicare minimum.

Finally, the State requests that HCFA grant any other waiver pursuant to Section 1115(a)(1) that HCFA deems to be required in order to implement the demonstration as described in this document.

B. Waivers Under Section 1115(a)(2)

New York requests that, pursuant **to** Section 1115(a)(2), HCFA participate in the following costs that would not otherwise be eligible for reimbursement under Medicaid.

Income Limitations

Section 1903(f) of the Act and 42 C.F.R. § 435.100 et. seq., prohibit payments under Medicaid to States which implement eligibility standards in excess of the maximums allowed by regulations. New York requests a waiver of these provisions to expand eligibility to

individuals receiving Home Relief Assistance. The expanded eligibility will not result in cost increases, because of the offsetting savings **from** other aspects of the demonstration.

Capitation Contract Requirements

Section 1903(m)(1)(A), (2)(A), and (2)(C) of the Act, and 42 C.F.R. § 434, prohibit payments to States that contract for comprehensive **services** on a prepaid or other risk basis unless such contracts are with entities that: (a) meet federal Health Maintenance Organization ("HMO") requirements or state **HMO** requirements; (b) maintain an enrollment composition of no more than 75 percent Medicare and Medicaid enrollees (except in cases of public **HMOs**, and federally qualified **community** health centers which received grants exceeding \$100,000 during the preceding two years); and (c) allow Medicaid members to disenroll at will on a monthly basis.

The State requests a waiver of §§ 1903(m)(1)(A) and (2)(A)(i) and 42 C.F.R. §§ 434.20 and 434.21 because the demonstration provides for contracts with fully capitated PHSPs and partially capitated plans in addition to state licensed health maintenance organizations.

The State also requests a waiver of **§ 1903(m)(2)(A)(ii)** and 42 C.F.R. §§ 434.20, 21, and 26, in order to allow contracts with capitated plans that do not meet the enrollment composition requirements of these **sections**. The State further requests a waiver of **§ 1903(m)(2)(A)(vi)** and 42 C.F.R. § 434.27 in order to require participants to remain with their initial choice of health plan, absent good cause, for one year.

Institutions for Mental Diseases

Sections 1902(a)(20), 1902(a)(21), 1903(f) 1905(a)(1), 1905(a)(14), 1905(a)(16), 1905(h), and 1905(i) of the Act, and implementing regulations, limit coverage for inpatient psychiatric care to individuals ages 21 and under, or 65 and over. New York **seeks** a waiver of these requirements in order to enable it to provide a **full** range of appropriate services to non-elderly adults requiring inpatient psychiatric care and alcohol and other **drug** treatment. New York requests a waiver of these sections to the extent necessary to cover inpatient psychiatric and alcohol and drug treatment for non-elderly adults between the ages of **22** and **64**, up to an aggregate annual limit of 90 days per enrollee.

CHAPTER SEVEN

DISPOSITION OF EXISTING & PENDING WAIVERS

New York State currently has a number of Section **1115** and Section **1915** waivers in operation or pending before the ~~Health~~ Care Financing Administration. Most of these waivers will not be affected by the current Section **1115** waiver and will continue in force. Other pending and existing waivers, however, are duplicative and will be withdrawn or allowed to expire, as appropriate.

The following is a catalogue of existing and pending waivers, **and** their disposition in light of the current Section **1115** waiver.

A. Existing Waivers

Southwest Brooklyn Managed Care Program

New York City has a Section **1915(b)** program in operation in Southwest Brooklyn. The waiver involves mandatory enrollment of AFDC children and adults into fully capitated health plans. **This** waiver will be subsumed into the statewide Section **1115** waiver.

Statewide Clinic Partial Capitation

This Section **1115** demonstration project, which requests a waiver of **the** upper payment limit, involves partial capitation of five clinics across the State for primary and specialty physicians' services, laboratory, and x-ray. **This** waiver, which has been verbally approved, will be withdrawn as the current Section **1115** waiver includes a request for waivers allowing partially capitated plans in areas that do not have the capacity for full capitation.

Substance Abusing Pregnant Women

New York State is one of five States participating in a multi-year section **1115** waiver demonstration project to test a variety of issues regarding outreach, engagement and treatment of pregnant substance abusers. Pursuant to this waiver, the State receives Medicaid reimbursement for services provided to substance abusing pregnant women in certified residential and drug-free ambulatory treatment programs. The waiver expires June **30, 1996** and, in light of the current waiver's provision for enrollment in a Special Needs Plan when appropriate, will not be renewed.

MAX Program

Broome County has in operation a Section **1915(b)** waiver for the MedicAideXtra (MAX) enhanced fee-for-service physician case management program. The program voluntarily enrolls AFDC and MA-only adults and children. The waiver, which is scheduled to expire on September **30, 1995**, will be continued only until the current Section **1115** waiver goes into effect.

Home and Community-Based Waiver for the Developmentally Disabled

The State has a Section 1915(c) waiver pursuant to which home and community-based services are provided to approximately 20,000 adults and children who meet the level of care for an ICF/MR. This waiver is unaffected by the current Section 1115 waiver and will continue in force.

Home and Community-Based Waiver for the Aged and Disabled (Long Term Home Health Care Program)

The State ~~has~~ a Section 1915(c) waiver program in which certified home health agencies provide home and community-based services to **almost** 20,000 aged and disabled individuals who are medically eligible for institutional level of care. Included in ~~this~~ waiver are "**AIDS** Home Care Programs" serving patients who have AIDS and who are medically eligible for placement in a hospital or residential health care facility. This-waiver is largely unaffected by the current Section 1115 waiver and will continue in force. However, the home and community-based services provided **through** AIDS Home Care Programs will be subsumed by the **AIDS** Special Needs Plan in the current Section 1115 waiver and will be phased out once the **AIDS** SNPs are **fully** operational.

Home and Community-Based Waiver for Persons with Traumatic Brain Injuries

The State has a Section 1915(c) waiver that provides home and community-based services to persons between the ages of 18 and **64** who have suffered a traumatic brain injury and who are clinically eligible for nursing facility care. This waiver is unaffected by the current Section 1115 waiver and will continue in force.

Home and Community-Based Waiver for Seriously Emotionally Disturbed Children

The Office of Mental Health has a Section 1915(c) waiver to provide home and community-based services to approximately 100 children who are seriously emotionally disturbed. This waiver is unaffected by the current Section 1115 waiver and will continue in force.

Care at Home "Model" Waivers

The State has five model "care at home" waivers under Section 1915(c). All provide case management, home adaptations, and respite services either to children discharged from hospitals to home (models 1, 2 and 5) or to developmentally disabled children who are otherwise eligible for **ICF/MRs** (models 3 and **4**). These waivers are unaffected by the current Section 1115 waiver and will continue in force.

Elderplan

Under a Section **1115** waiver, Elderplan, a Social Health Maintenance Organization in Brooklyn, provides ~~fully-capitated~~ services to SSI and medical assistance-only individuals over age **65** who are covered under Medicare parts A and **B**. Elderplan does not include nursing home care and personal care services. **This** waiver, currently in its 9th year, is unaffected by the current Section 1115 waiver and will continue in force.

Program for All-Inclusive Care for the Elderly ("PACE")

There currently are two Section **1115** federal Medicaid waivers for two participating sites in the PACE demonstration: Beth **Abraham's** Comprehensive Care Management project in the Bronx and Rochester General Hospital's Independent Living for Seniors. The PACE project is testing a full-risk, capitated risk-based model which requires a single provider to provide or arrange for a comprehensive range of primary, acute and long term care services to persons who are dually eligible for Medicare and Medicaid and are clinically appropriate for nursing facility level care. Approximately **250 frail** elderly are currently enrolled in each of the two existing programs, and similar programs are under review. The PACE waivers will be unaffected by the current Section **1115** waiver.

B. Pending Waivers

New York City Managed Care Program

New York City **has** pending a Section **1915(b)** waiver to mandatorily enroll all AFDC and AFDC-related Medicaid recipients into fully capitated health plans citywide. The waiver was submitted February **22,1995**, and is expected to **go** into effect on June **1,1995**. This waiver will be subsumed into the statewide Section **1115** waiver.

Westchester County Managed Care Program

Westchester County has pending a Section **1915(b)** waiver to mandatorily enroll most Medicaid recipients (except those **receiving** long term care) into fully capitated health plans. The waiver was submitted on January **23,1995**, and is expected to go into effect on October **1,1995**. This waiver **will** be subsumed into the statewide Section **1115** waiver.

Transportation

The State currently **has** pending a Section **1915(b)** waiver request to allow local social service districts to provide non-emergency transportation through one designated provider. The pending waiver is being withdrawn **as** the current Section **1115** waiver includes requests for waiver of statewideness, comparability and freedom-of-choice that apply, among other things, to the option of local districts to provide non-emergency transportation through a designated provider.

Voluntary Mail Order Prescription Drugs

The State currently has pending a Section **1915(b)** waiver request to permit voluntary mail order prescription drugs for Medicaid recipients from districts outside of New York City. The waiver would **permit** the State to contract with **a** single mail order provider to provide access to drugs to recipients who live in rural and outlying regions of the State where pharmacy services may be limited. The State implemented such a service in **1991** and sought a waiver in **1994** after being informed that a waiver would be required. The pending waiver is now being withdrawn. Under the current section **1115** waiver, in most areas of the State, pharmacy benefits **will** be provided through fully capitated managed care plans. In those areas of the State with partially capitated plans, local districts will have the option of providing drugs through a voluntary **mail** order program. The current Section **1115** waiver includes requests for waiver of statewideness, comparability and freedom-of-choice that

apply, among other things, to the option of local districts to allow recipients to obtain drugs through a voluntary mail order program.

APPENDIX 1

**MEDICAID MANAGED CARE:
HEALTH SYSTEMS CAPACITY ISSUES**

Medicaid Managed Care: Health System Capacity Issues

Overview

New York State has a sufficient number of physicians and hospital beds to serve 1.8 million people in Medicaid Managed Care. The challenge will be the mechanics of redistributing the service of physicians from overserved areas to underserved areas, contracting with a sufficient number of private practitioners and health facilities, and expanding capacity in rural areas. Using a combination of our existing resources and surplus of health care providers, the State and its counties and cities can meet this challenge.

The ratio of full-time-equivalent primary care physicians to the population of the State is well above national and state standards and far above typical HMO standards. All 5 boroughs in New York City and 13 of the other 16 urban counties in the State meet or exceed the minimum managed care service delivery requirements of primary care physician-to-population ratios. The real problem is not lack of doctors but their distribution within each metropolitan area. Only 17 of 44 rural counties have enough primary care doctors, however.

A number of publicly-financed strategies will be used to redistribute primary care resources to meet the needs of underserved areas. Fortunately, most of these programs have already been implemented by the state. For example, the state has invested over \$130 million during the past 5 years to develop and expand primary care service sites in underserved areas. Other programs are also providing additional millions of dollars for capital development. We also have loan repayment and scholarship programs in which physicians, nurse practitioners, and physician assistants receive financial assistance in return for locating in underserved areas. The State administers the Rural Network Development Program, which is currently focusing on 23 counties. We just awarded grants to medical schools and residency training programs to train more primary care physicians and to retrain specialists in primary care.

Other resources are available to help meet the need for primary care. Many hospitals, which play a central role in delivering primary care in New York City, are investing millions of dollars of their own funds to establish new service sites. A valuable resource is the 1100-plus physicians who complete residency training in the State every year and go into primary care. Incentives, such as bonuses and salary enhancements, can be given to encourage doctors to provide services to targeted underserved population groups. Public transportation systems can also help address underserved areas as most of these areas are contiguous to areas with an oversupply of practitioners.

Presented below is a description of the capacity currently existing in New York State to deliver Medicaid Managed Care, and how that capacity can be used more effectively and efficiently to assure access to needed services for all Medicaid recipients.

Managed Care Penetration

- Of the **1.8** million Medicaid eligibles targeted for enrollment in managed care by July **1996**, **26** percent are currently enrolled in managed care. However, counties vary greatly in enrollment patterns, with **15** counties (all of them rural) having no Medicaid eligibles enrolled in managed care and **5** counties having exceeded **50** percent of their targeted enrollment.

"Pipeline" Managed Care Capacity

- The managed care industry in New York has grown exponentially during the past decade. In January **1984**, New York had **13 HMOs**, with **1.3** million enrollees, and was just developing its Prepaid Health Services Plans (PHSPs). Today, there are **30 HMOs**, **11** PHSPs, and **16** partial capitation plans, serving about **4.3** million individuals, including almost **495,000** Medicaid recipients.
- Information submitted by **HMOs** and PHSPs to the Departments of Health and Social Services indicate the following capacity expansion for a three year period ending June **1998**: by July **1995**, there will be an additional **525,000** Medicaid managed care slots available; new capacity will increase to **625,000** by September **1995**, will surpass **700,000** by January **1996**, and will reach **736,000** by June **1996**, the end of the first year of implementation. By June **1998**, a cumulative total of **1.3** million additional slots will be available. Of these additional Medicaid slots, over **95** percent are located in the New York metropolitan area.
- These figures reflect growth under a voluntary approach to Medicaid managed care. Expansion of the state's PHSP and HMO capacity must be further accelerated. The New York **State HMO** Conference has indicated its support for a mandatory Medicaid managed care program and its intent to make available further Medicaid managed care capacity. Medicaid enrollment in PHSPs reached **167,000** in March **1995**. An additional **200,000** PHSP slots will become available by July **1995**, increasing to more than **400,000** by June **1996**, and to almost **750,000** by June **1998**.

Importance of Institutional Participation

Most Medicaid FFS Visits Occur in Institutions

- One of the most important ways to achieve sufficient capacity is to make sure institutional providers, **i.e.** hospitals and diagnostic and treatment centers (D&TCs), enter into contracts with one or more **HMO** or Prepaid Health Services Plan (PHSP) that serve the Medicaid population. In the five boroughs of New York **City**, **75** percent of the Medicaid (under **65**) fee for service (FFS) visits are provided in D&TCs, hospital based clinics and emergency

rooms.' In the state's **13** other urban counties, about **85** percent of these visits are provided in institutional settings. In the **44** rural counties, over 70 percent of these visits **are** provided in institutional settings. If we assume these institutions will choose to continue to serve their Medicaid populations (which is likely), then they will contract with a HMO or PHSP provider network or become a PHSP in their own right.

Institutional Participation Will Help Meet the Need for Medicaid Managed Care

- One of the chief vehicles for successfully moving the Medicaid population to managed care is to ensure that ~~the~~ institutions do, in fact, contract with an HMO/PHSP, or form their own managed care organization. Expanding HMO/PHSP contracts with facilities or allowing facilities to form their own managed care organization will assure capacity for a significant number of the Medicaid managed care population. We must facilitate the institutions, efforts to enter into such contracts and focus on enrolling private practitioners.

Primary Care Facility Distribution in New York City

- Primary care facilities (hospital outpatient departments and multi-purpose and family planning clinics) provide **services** in most neighborhoods in New York City: in all **11** Health Systems Agency (HSA) neighborhoods in Manhattan; in **14** of the **15** HSA neighborhoods in Brooklyn; in **7** of the **9** HSA neighborhoods in the Bronx; in **13** of **18** HSA neighborhoods in Queens; and in **4** of **5** HSA neighborhoods on Staten Island.

Excess Hospital Beds

- According to the Department's bed need methodology, which projects hospital beds needed through **1996**, New York has **11,000** excess acute care hospital beds statewide. Only one county is below (by **2** percent) its projected need. Where excess capacity exists, there is opportunity to convert acute care beds to fulfill unmet need for alcohol rehabilitation and detoxification beds, and in some regions for physical medicine rehabilitation or psychiatric beds.

Physician Capacity

Sufficient Number of Physicians

- There are over **49,000** physicians practicing in New York State and **14,000** residents training in **NYS**. Adjusting for ~~those~~ practicing part-time, there **are 43,000** FIE physicians (residents **are** counted **as 0.25** FTE). Of these, nearly **13,400** FIE physicians and residents provide **primary** care **services**, of whom **1,450** are primary care FTE residents. **This** number **does not** include the approximately **7,000** nurse practitioners, physician assistants or midwives who

¹ This includes over 3.2 million outpatient psychiatric visits and 1 million MMTP visits out of a **total** of 20 million visits. There is very little reported usage of these services in physicians, offices.

currently practice in NYS.

Maldistribution of Primary Care Physicians

- **The ratio** of total FTE primary care physicians to the population of New York State is **74** per **100,000**, well above the New York State-specified Medicaid managed care service delivery network requirement range of **53 to 65** per **100,000**. **The most significant issue with the existing capacity is the maldistribution of primary care physicians.**

Primary Care Physician Pipeline Capacity

- Over **1,100** physicians complete primary care residency programs and enter primary care practice in New York State annually. Although some choose to practice in other states, a significant number remain in New York State. The New Resident Loan Repayment program requires recipients of awards to practice primary care in New York State after completion of training.

Most People Live in Counties with Sufficient Capacity

- **All** five New York City boroughs and **10** of **13** upstate urban counties meet or exceed the **minimum** service delivery network requirement of **53** primary care physicians per **100,000**. Of the **44** rural counties, **17** meet or exceed the **minimum** service delivery network requirement. Eighty-six percent of the state's population resides in the counties that meet or exceed the requirement.

Most Medicaid Enrollees Live in Counties with Sufficient Capacity

- Of the nearly **495,000** people already enrolled in Medicaid managed care programs, **94** percent, or about **470,000**, live in counties with adequate primary care capacity (i.e., more than **53** primary care physicians per **100,000**). **Of the 1.8 million to be enrolled by July 1996, about 92 percent, or 1.7 million, live in counties with adequate primary care capacity.**

Most Medicaid Enrollees in New York City Live in Neighborhoods with Sufficient Capacity

- In **all 58** New York City **HSA** neighborhoods, approximately **38** neighborhoods, or **66** percent, have an adequate supply of primary care physicians.
- **Of the 2.2 million total Medicaid eligibles residing in New York City, about 71 percent, or 1.6 million, live in the 38 New York City neighborhoods where primary care physician supply is adequate (i.e., greater than 53 per 100,000).**
- All of the neighborhoods **below the managed care service** delivery network requirement range are adjacent to neighborhoods which **meet** or exceed the range. Some physicians could locate in or commute to the underserved neighborhoods and some enrollees could use the subway

and bus lines to access physicians in overserved areas.

Maldistribution of OB/GYNs

- o There are approximately **3,500 FTE obstetrician/gynecologists** in New York State. Many women currently use their OB/GYN as their primary care provider. The ratio of OB/GYNs to the population of New York State is 19 per **100,000**, higher than the New York State-specified Medicaid **managed care service** delivery network requirement range of **10 to 12** per 100,000. **Again, the most significant issue with the existing capacity is maldistribution.** Sixteen of **18** urban counties meet or exceed the minimum requirement of **10** OB/GYNs per 100,000. However, only **8** of **44** rural counties meet or exceed this requirement. (These figures do not include approximately 500 midwives).

Resources for Underserved Areas

- o **All** major metropolitan areas of the state are located in counties where primary care physician capacity is adequate. However, some areas within counties (e.g., certain neighborhoods in New York City and the upstate cities) are underserved. Many of these areas are located in federally designated Health Professional Shortage Areas and, as such, qualify for both state and federally funded primary care practitioner incentive programs and development grants.
- o New York State will address maldistribution as well as shortages of primary care providers for Medicaid managed care through the following initiatives: the Primary Care Initiative; the Physician Placement Program; Physician Loan Repayment; the Rural Health Network Development Program; the New York City Primary Care Development Program; the primary Care Service Corps (service obligated scholarships for nurse practitioners, physician assistants and midwifery students); workforce development; and grants to retrain specialists in primary Care.
- o Federal and state primary care practitioner recruitment and incentive programs will support the placement of over **275** physicians and mid-level practitioners in 1995.

Excess Specialists Can and Do Provide Primary Care

- **NYS** has an excess of 10,000 specialist FTEs. The number represents **73** percent more specialists than needed. As managed care penetration grows and demand for specialists declines, there will be opportunities to increase our primary care capacity by encouraging specialists to provide primary care. Specialists acting as primary care providers can play a significant role in meeting the needs of special populations enrolled in managed care. Currently, nearly **2,900** specialists report that they are also board certified in primary care specialties.

Use of Non-Physician Primary Care Practitioners

- Shortages of primary care physicians can, in part, be addressed by New York State's nurse practitioners and physician assistants who provide primary care. Federal productivity standards equate one of these practitioners to a half time physician. Of the approximately **3,700** nurse practitioners and **2,900** physician assistants **licensed** to practice in New York state, an estimated **3,100** (**1,600** nurse practitioners and **1,500** physician assistants) work in primary care. Using ~~the~~ productivity standards above, this expands the primary care provider capacity by approximately **1,550FTE**.

Most Primary Care Physicians in Private Practice Already In Managed Care

- Over **75** percent of primary care physicians in solo or group practice in New York State report participating in one or more managed care plans or other prepaid practice arrangements; over **43** percent report participating in three or more managed care plans or other prepaid practice arrangements.

Most Specialists Already In Managed Care

- Almost **78** percent of **specialty** physicians in solo or group practice in New York State report participating in one or more managed care plans or other prepaid practice arrangements; nearly **48** percent report participating in three or more managed care plans or other prepaid practice arrangements.

Qualifications of Primary Care Providers

- In New York State, **90** percent of primary care physicians (principal specialty) are graduates of accredited residency programs; **70** percent are board certified or eligible in their specialty; **84** percent have admitting privileges to at least one hospital. Ninety-one percent of all primary care physicians are board certified/eligible or have admitting privileges. None of the state's **2,900** primary care **FTE** residents is included in these percentages. Managed care plans use a number of criteria to determine whether a physician is qualified to be a primary care physician.

Potential for Improved Physician Participation under Medicaid Managed Care

- The current level of fee-for-service primary care physician participation **in** Medicaid is not **high**. Moreover, **as** the dollar level of participation in the program increases, the number of participating physicians decreases. Of the more than **13,000** primary care physicians in New York State in solo or group practice, there were about **3,500** (**27** percent) with more than **\$5,000** **in** Medicaid billings for the federal **fiscal** year **1992-1993**. Of that group, only **830** billed more than **\$35,000**. These **figures** do not include additional revenues that may have been earned by physicians through participation in existing Medicaid managed care plans.

- Low reimbursement rates for fee-for-service Medicaid enrollees have discouraged private physician participation in the program. This might be expected to change as more adequate reimbursement under an expanded Medicaid managed care program becomes available.

Rural Health Capacity

Rural Counties Have Limited Medicaid Managed Care Capacity

- Of the state's 44 rural counties, 29 currently have full capitation managed care plans that have already enrolled Medicaid clients. Twelve of the 44 may meet the criteria for exemptions from enrolling all Medicaid eligibles in fully capitated managed care plans. In addition, 13 others have primary care physician to population ratios of less than 45 per 100,000 (e.g., significantly lower than the New York State-specified Medicaid managed care service delivery network requirement range of 53 to 65). These 13 counties will face greater challenges in meeting the full capitation enrollment levels because they will require new, additional resources.

Rural Health Network Program

- The Department of Health's Rural Health Network Program is funding 17 rural health networks covering 23 counties, including 5 of those counties that may qualify for the exemption, and 8 others that have primary care physician to population ratios below 45 per 100,000. The 23 counties have almost 160,000 Medicaid eligibles of which 16,000 (10 percent) are enrolled in full capitation managed care plans. The Medicaid managed care program has targeted enrollment levels in these counties to increase to 79,000, requiring increased enrollments of 63,000. Seven of these 23 counties have no Medicaid clients enrolled in fully capitated managed care plans.

Strategy For Increasing Managed Care in Rural Areas

- The strategy to increase enrollment levels in Medicaid managed care in rural areas will be to facilitate the efforts of counties to identify local providers and managed care plans in which Medicaid recipients can be enrolled. We will work with counties to help convene appropriate state and local interest groups that individually or in collaboration have the capacity to develop, or participate in, managed care plans. Direct technical assistance will be provided at the local level to help providers complete risk analyses and initiate start-up and set-up of needed monitoring and information systems for managed care. To the extent possible, the strategy will give priority to the development of managed care capacities through locally organized networks to enable maximum maintenance of local direction (governance) and operation of rural health care delivery systems.

Special Populations

Alcoholism and Other Drug Services

- Medicaid **managed care programs** will likely increase the demand for alcohol and other drug (AOD) services in New York State by **an estimated 27,000** persons **as** providers begin to prescribe additional AOD **treatments** to improve health status and thereby decrease the need for AOD-related medical care and its attendant costs.
- The following AOD **service need estimates** are based on the **1.3** million additional Medicaid eligibles **to** be enrolled in managed care by July **1996**:
- **Of** the nearly 160 AOD outpatient counselors needed for Medicaid managed care enrollees statewide, almost **43** percent are needed in NYC and about **18** percent are needed in Long Island. Currently Albany is the only major metropolitan city meeting Medicaid managed care needs for outpatient alcoholism services.
- Of the **151** inpatient beds needed for Medicaid managed care enrollees statewide, about **48** percent of the unmet need (**72** beds) is in Long Island, and **25** percent (**38** beds) is in New York City.
- New **York** City and Long Island Medicaid managed care enrollees will need 50 percent of the statewide Medicaid **managed** care need of nearly **170** emergency beds. Of the 170 beds, an additional **37** percent is needed in non-urban counties.
- About 1,350 Medicaid managed care clients statewide would need Methadone Treatment, with about **80** percent of those, or **1,100** residing in New York City.

AIDS and HIV

- The total statewide estimated number of persons who are HIV positive or have **AIDS** is **200,000**, of which about **50** percent, or **100,000**, are Medicaid-eligible.
- At current case-finding levels, most **areas** have adequate capacity to provide care to all Medicaid-eligibles consistent with the performance standards and clinical practice guidelines developed by the **AIDS** Institute (AI) for certification of provider capability. The attached maps provide a geographic display of Medicaid providers of services to persons with **HIV/AIDS**.

The AI has only anecdotal evidence of service gaps, primarily in rural areas but also in urban areas, particularly NYC.
- **All** providers participating in **HIV/AIDS** Special **Needs** Plans will be certified. All providers

participating in managed care plans that enroll persons who are HIV positive or who have **AIDS** will meet AI performance standards. The AI will inventory the capability of existing non-certified providers and **will** target resources to them to facilitate their certification (for SNPs) or their ability to meet the performance standards (for managed care plans).

Mental Health

- o Approximately 100,000 Medicaid eligibles are diagnosed **as** seriously and persistently **mentally** ill (SPMI). About half of these individuals, or 50,000 SPMI Medicaid eligibles **are** targeted for ~~the~~ base benefit **managed** care package, while the rest are targeted for the special needs package.
- o **Acute Inpatient. Adult - Based** on the Office of Mental Health's 1995 plan for overall mental health **service** need, approximately 90 percent of the Medicaid bed need has been met for the adult inpatient population. Of the estimated statewide unmet Medicaid need of 410 beds, **280 (65 percent)** of those beds are needed for the New York City region. The balance of the unmet need is distributed throughout the rest of the state.
- o **Acute Inpatient. Children and Youth** - Approximately 70 percent of the Medicaid bed need has been met for the children and youth population. Of the estimated statewide unmet Medicaid need of 95 beds, **55 (57 percent)** of those beds are needed for the New York City area. The New York City region has more than twice the unmet Medicaid need of any other region. **The** balance of the unmet need is distributed throughout the remaining four regions.
- Three OMH initiatives will continue to have a positive impact on reducing unmet inpatient need:
 - Continued development of Comprehensive Psychiatric Emergency **Programs** within the general hospital industry to stabilize and assess the needs of the patient.
 - Guaranteed access to services and support systems through the Intensive Case Management Program.
 - Continued conversion of excess acute medical/surgical beds in Article **28** hospitals to psychiatric **care beds**.
- **Outpatient Programs**
 - Clinic Programs - OMH does not project public need for clinic capacity. Clinic capacity is substantial across the state and in the short run can serve **as** a substitute for needed Intensive Psychiatric Rehabilitative Training Programs and Partial Hospitalization **Programs**.

- Partial Hospitalization Program - Proportionately, this program has the highest estimated unmet Medicaid need of **835** slots or **55** percent. Started in 1991, this program offers an alternative to acute care hospitalization, and is under development where needed.
- Continuing Day Treatment and Intensive Psychiatric Rehabilitative Treatment Programs - 80 percent and **75** percent of the Medicaid need has been met, respectively, in these programs. The estimated unmet Medicaid need (**2,475** slots needed for continuing day treatment and **375** slots needed for intensive psychiatric rehabilitative **training**) is expected to be satisfied as pipeline and converting programs become licensed under OMH ~~Part~~ **587** regulations.

Office of Mental Retardation and Developmental Disabilities

- The **OMRDD** provides ~~services~~ to approximately **93,000** clients; **60,000** are on Medicaid, of which 18,000 are targeted for managed care enrollment. In addition to the **93,000** people the system serves there are another estimated 9,000 people needing OMRDD services but **receiving** none. It is estimated that **3,800** of the 9,000 people needing services would qualify for Medicaid managed care bringing the total Medicaid eligibles to be enrolled in managed care to 21,800. Sixty percent of this unmet need is located in the New York City area.

Department of Veterans' Affairs (VA) Health Care System

- The VA system is a potential source for increasing the service delivery capacity for Medicaid **managed** care. In New York State, 12 VA Medical Centers provide a comprehensive range of **services**, including primary care, substance abuse and alcohol abuse treatment, services for persons with spinal cord injury, prosthetic devices and services, hospice and respite services, and services for persons with HIV/AIDS. The twelve VA Medical Centers (VAMCs) are spread **across rural** and inner city locations (three in New York City alone) and have a total capacity of **4,784** beds. **All VAMCs** operate outpatient programs, and the system includes seven additional satellite centers in rural and urban **areas** throughout the State.
- **As** major medical centers offering comprehensive inpatient and outpatient services, VAMCs are equipped to function **as** managed care organizations serving the Medicaid population. The directors of all twelve VAMCs in the State have expressed interest in becoming sources of managed care for veterans who are Medicaid eligible. **This** includes provision of managed care for dependents, where service capacity and subcontracting arrangements would permit. **The** directors **of** several of **the** centers have **also** expressed interest in providing managed care through sharing agreements with **HMOs** and other managed care organizations. We will continue discussions with **the** directors of **the** VAMCs to develop a formal agreement for VA participation in the Medicaid managed care program, an agreement which **will** include

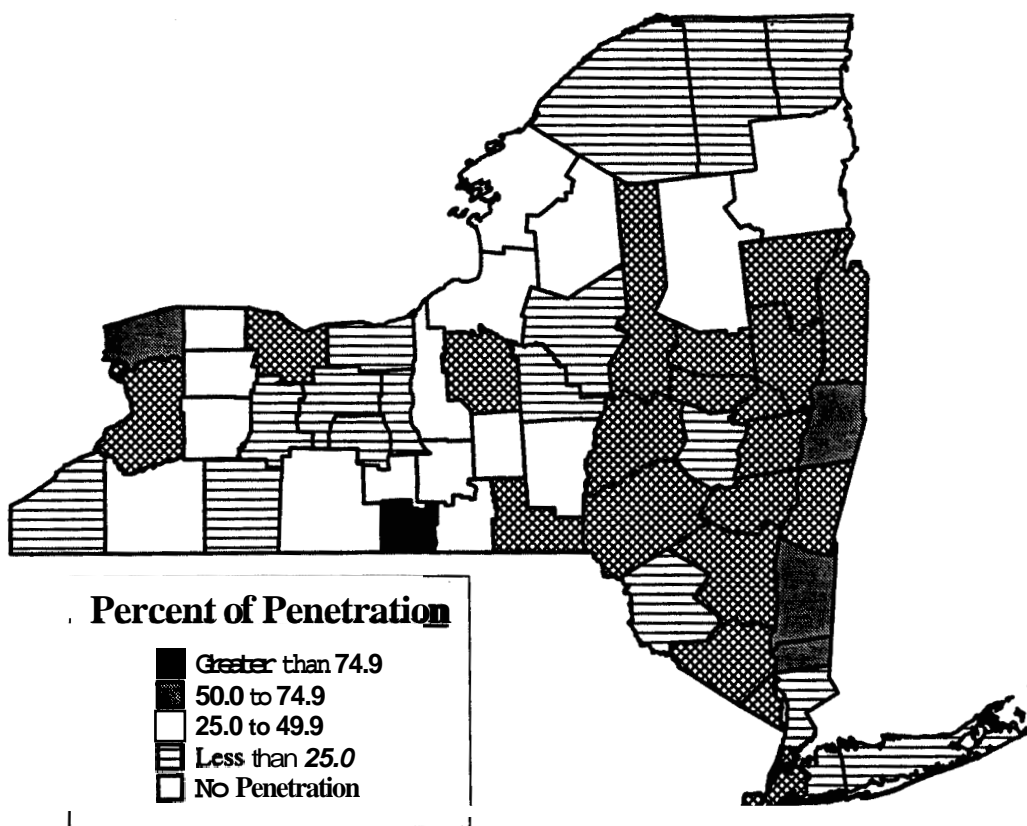
appropriate remuneration to the **VAMCs** for their managed care service.

- The participation of the **VAMCs** in Medicaid managed care would further enrich the primary and specialty care services available to Medicaid populations. The VA system would offer primary care at 19 sites and locations throughout the state, and would make available the services of some 100 primary **care** physicians statewide. In addition, many of the estimated 100,000 Medicaid eligible veterans in New York State have special health needs, such as alcohol, substance abuse and mental illness problems, and would feel more comfortable seeking care from the VA. Veterans may **also** constitute as much as 30 percent of the homeless, a population which is likely to have multiple health **needs** and which generally has not been reached by **HMOs** and other providers. The VA system's resources could also be a particularly valuable source of services for Medicaid clients whose needs for special therapies, rehabilitation and assistive devices could not be readily met by most **HMOs** or other managed care providers.

*Maps, Charts and Other Supporting
Materials*

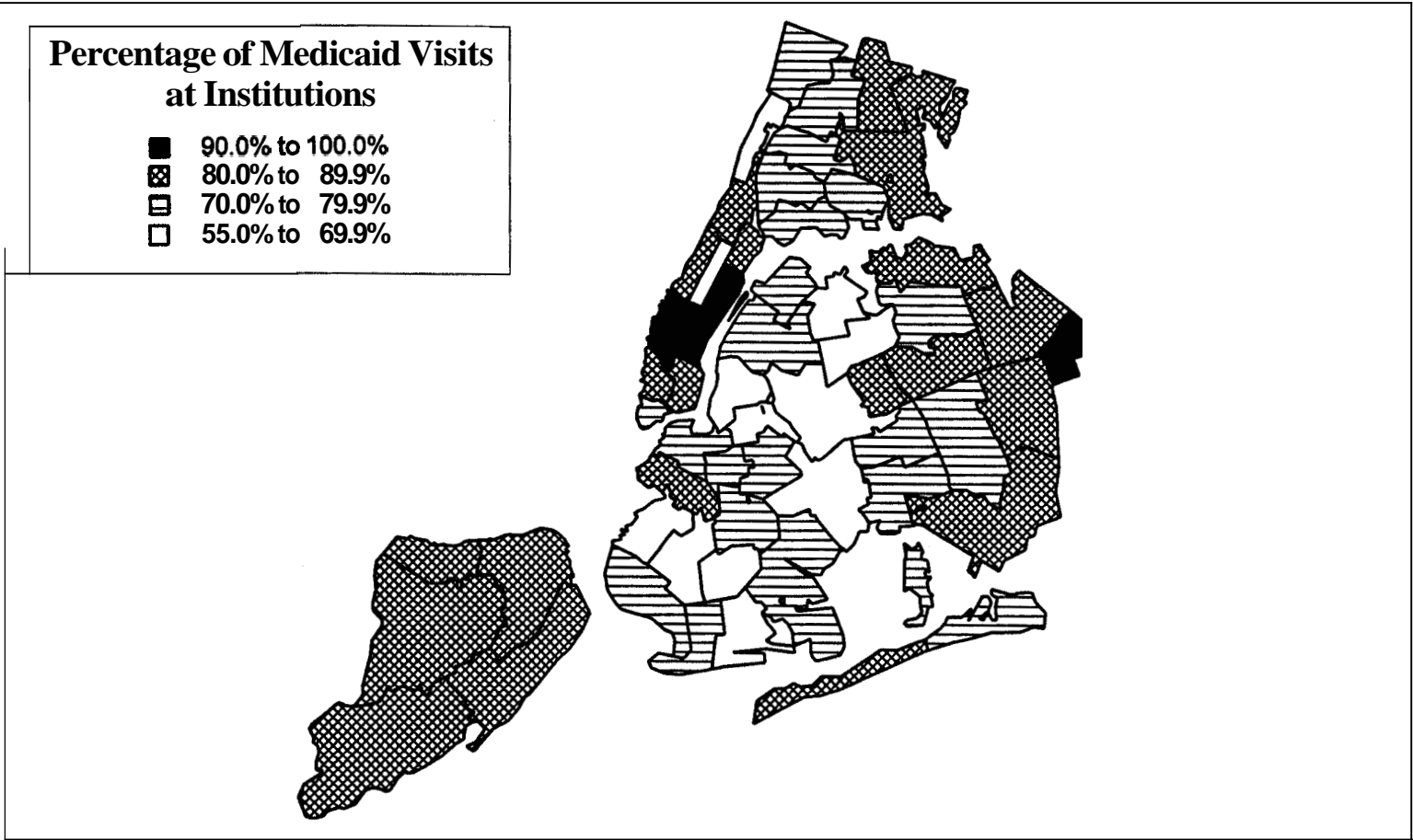
Current Medicaid Managed Care Enrollees as a Percent of Targeted First-Year Medicaid Enrollees (1.8 Million)

New York State, February 1995



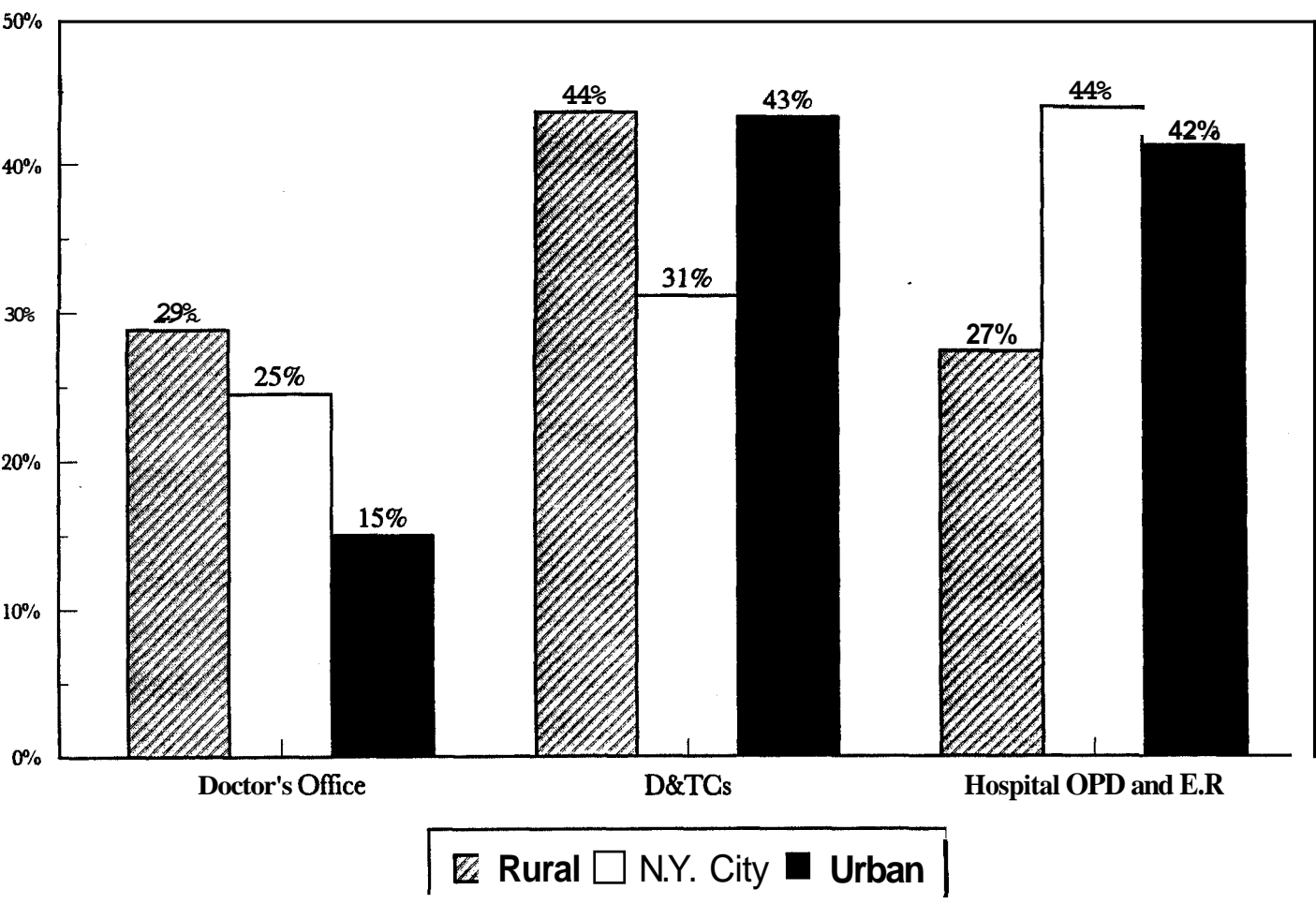
- Of the 1.8 million Medicaid eligibles targeted for enrollment in managed care by July 1996, 26 percent currently **are** enrolled in managed care. However, counties vary greatly in enrollment patterns, with 16 counties (all of them **rural**) having no Medicaid eligibles enrolled in managed care and 5 counties having exceeded **50** percent of their targeted enrollment. (Although these numbers **are** based on pre-waiver DSS eligibility methodologies and **are** subject to revision, it is expected that the revised methodology will yield numbers leading to similar conclusions).

Percentage of Medicaid Visits at Hospital Based OPDs and D&TCs by New York City Neighborhoods of Residence



- One of the most important ways to achieve sufficient capacity is to make sure institutional providers enter into contracts with one or more managed care organizations that serve the Medicaid population (HMOs/PHSPs). In the five boroughs of New York City, 75% of the Medicaid FFS visits are provided in institutional settings. It is highly probable that these institutions will want to continue to serve their Medicaid populations, so they will contract with an HMO/PHSP. This will provide capacity for a significant number of the Medicaid managed care population. The capacity question then becomes enrolling sufficient primary care doctors into HMOs/PHSPs to service the residual Medicaid population.
- Although 75% of the Medicaid FFS visits occurred in institutions, this does not signify that enough capacity exists to treat all of the population in New York City. In fact, 20 of the 58 NYC neighborhoods shown on the map are below the service delivery network requirement of 53 primary care physicians per 100,000 population, and therefore have an insufficient number of doctors.
- Institutional visits include 32 million psychiatric outpatient visits, as well as 1 million methadone maintenance treatment program visits. There is very little reported usage of these services at physician offices. Total visits in New York City are 13 million.

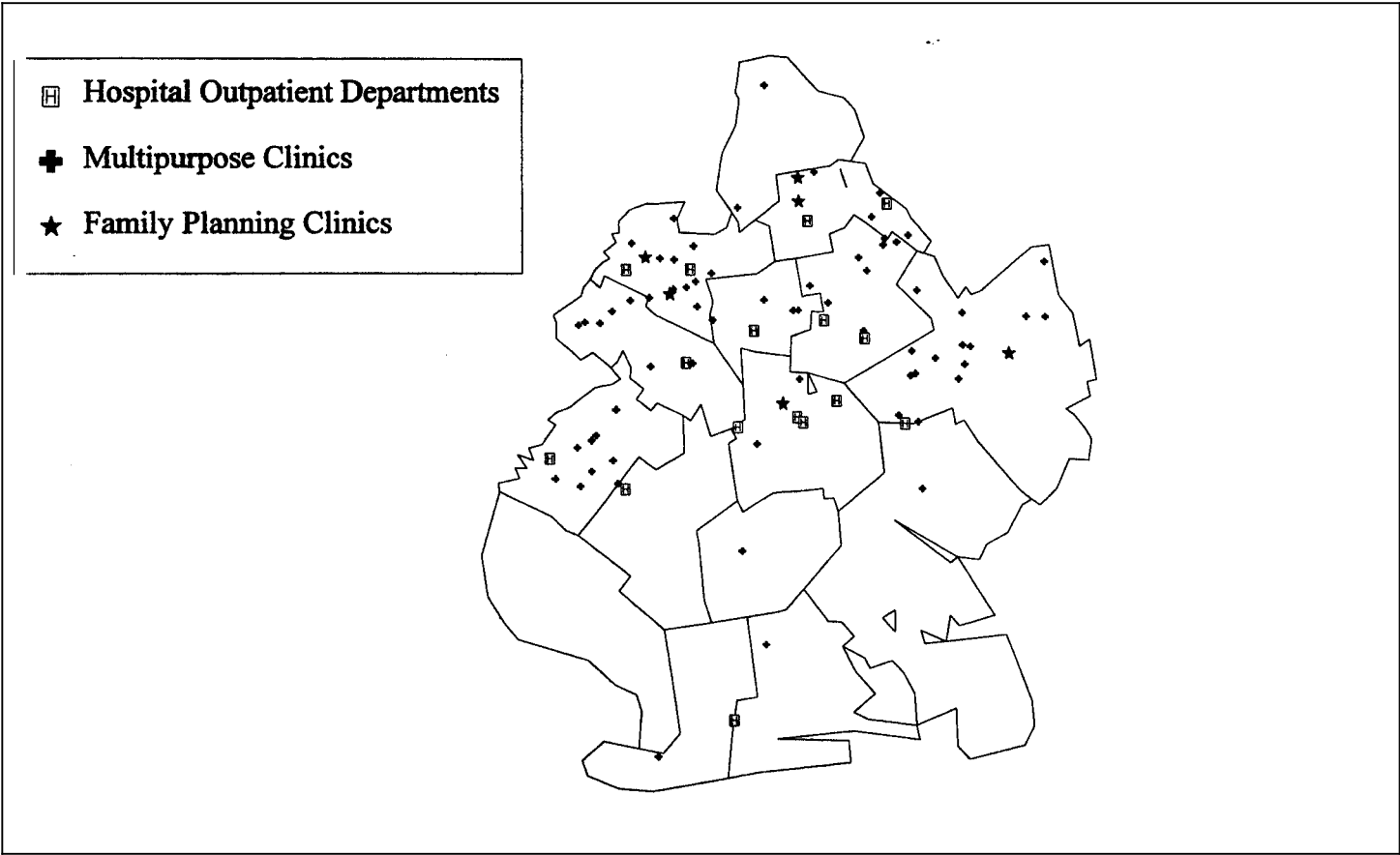
Medicaid Fee For Service Visit Setting



One of the most important ways to achieve sufficient capacity is to make sure institutional providers, i.e. hospitals and diagnostic and treatment centers (D&TCs), enter into contracts with one or ~~more~~ managed care organizations that serve the Medicaid population, either an **HMO** or a **PHSP**. In the five boroughs of New York City **75%** of the Medicaid fee for service (**FFS**) visits are provided in institutional settings. In **urban** counties, **85%** of the Medicaid FFS visits are provided in institutional settings. In rural counties, (populations of less ~~than~~ 200,000), over **70%** of the Medicaid FFS visits **are** provided in institutional settings. If we assume these institutions will want to continue to serve their Medicaid populations, then they will contract with a **HMO** or **PHSP** or become one in their own right. This will provide capacity for a significant number of the Medicaid managed **care** population. The capacity issue then becomes enrolling sufficient primary care doctors in **HMOs** or **PHSPs** to serve the residual Medicaid population.

Primary Care Facility Sites by Health Systems Agency Neighborhood

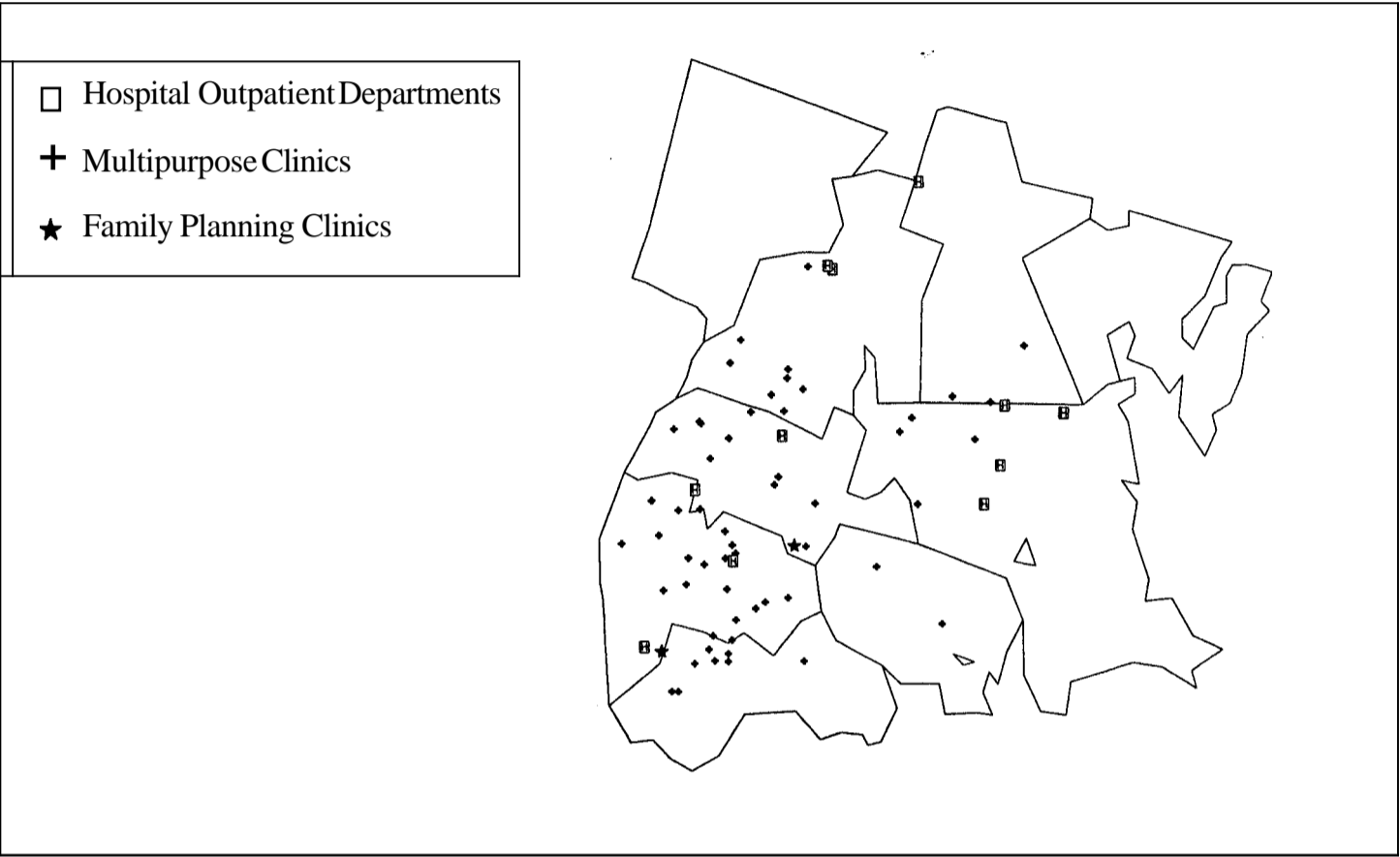
Brooklyn, February 1995



- Primary care facilities provide services in 14 of the 15 Health Systems Agency neighborhoods in Brooklyn.

Primary Care Facility Sites by Health Systems Agency Neighborhood

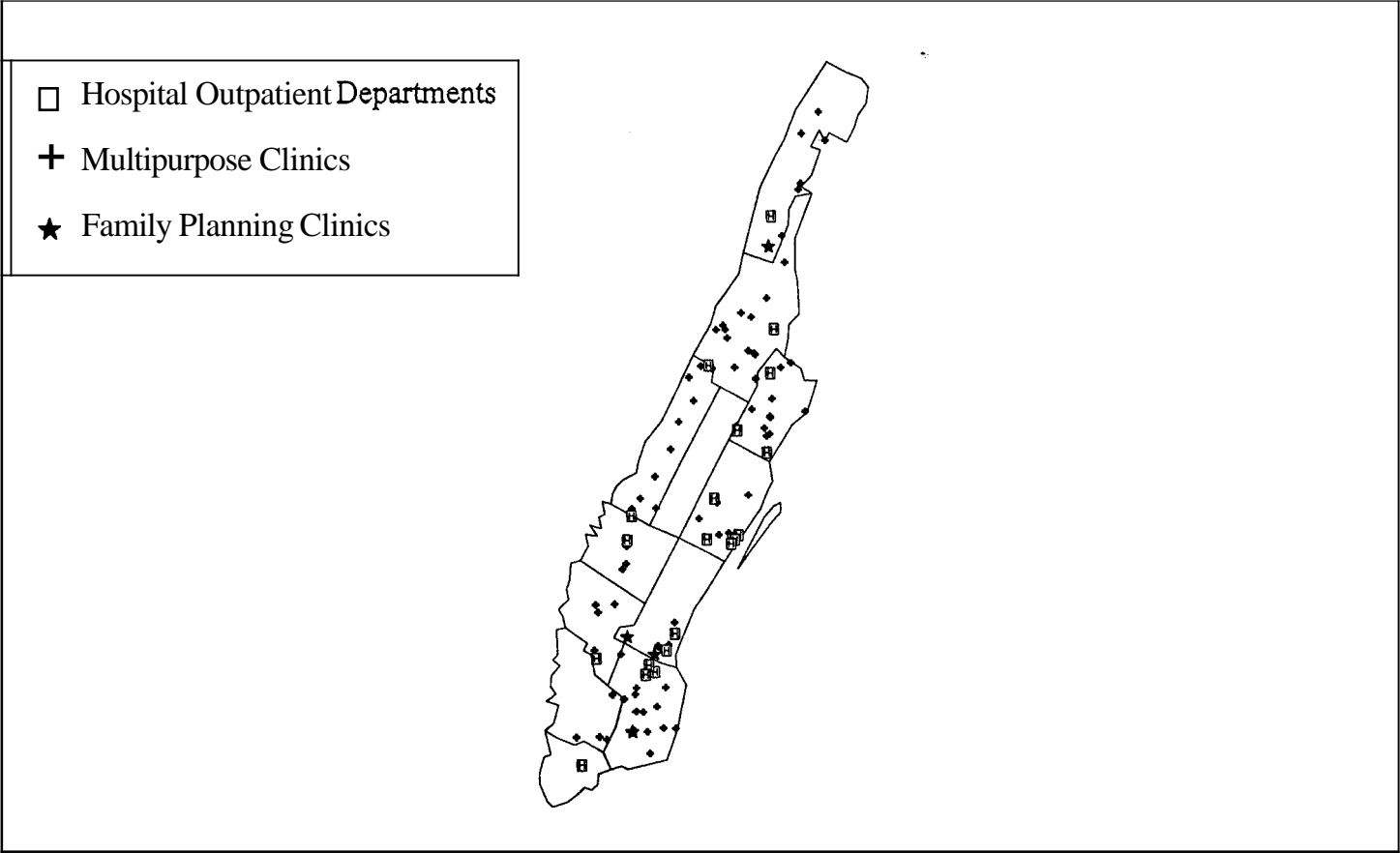
Bronx, February 1995



- Primary care facilities provide services in 7 of the 9 Health Systems Agency neighborhoods in the Bronx.

Primary Care Facility Sites by Health Systems Agency Neighborhood

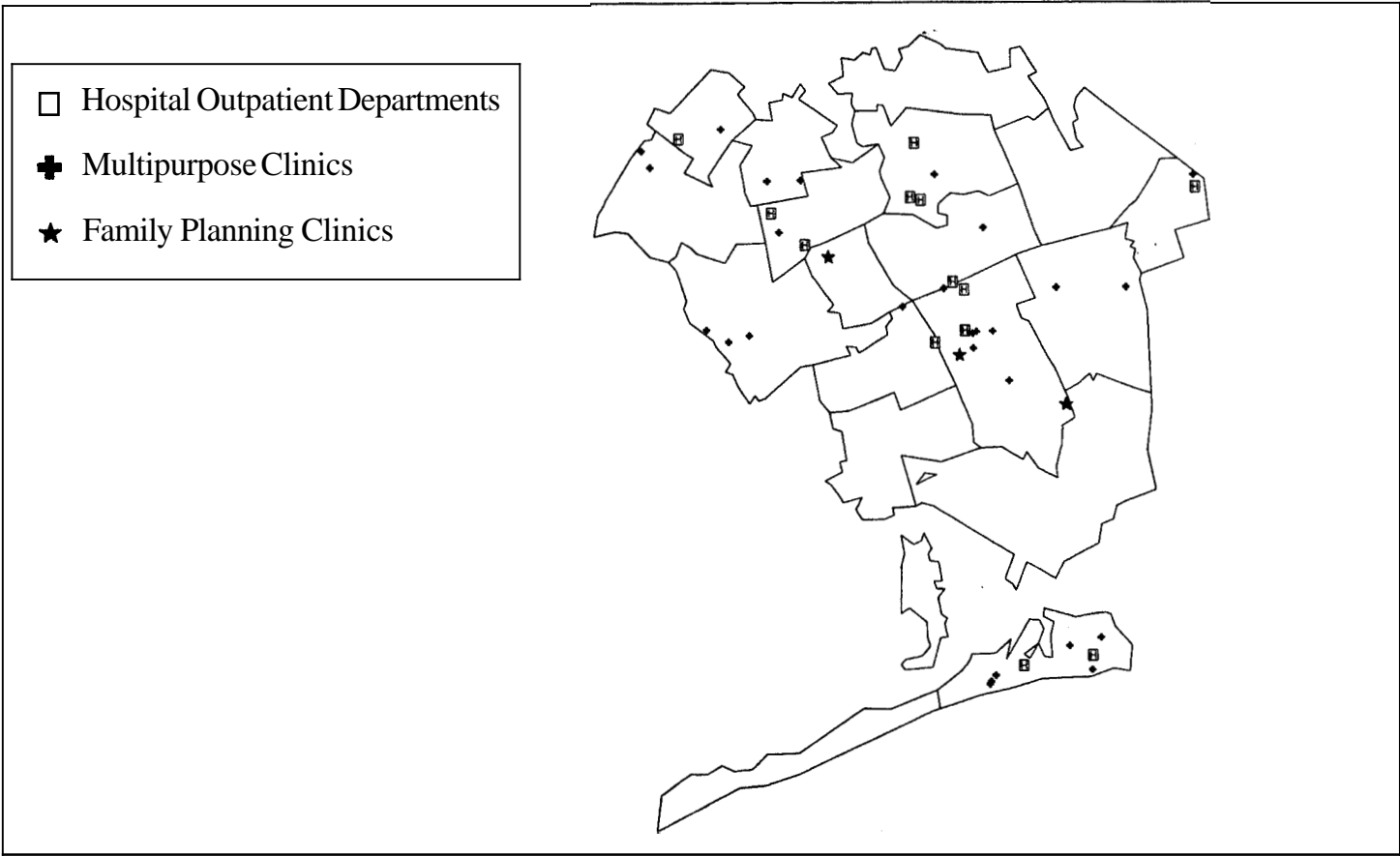
Manhattan, February 1995



- **Primary care facilities provide services in all 11 Health Systems Agency neighborhoods in Manhattan.**

Primary Care Facility Sites by Health Systems Agency Neighborhood

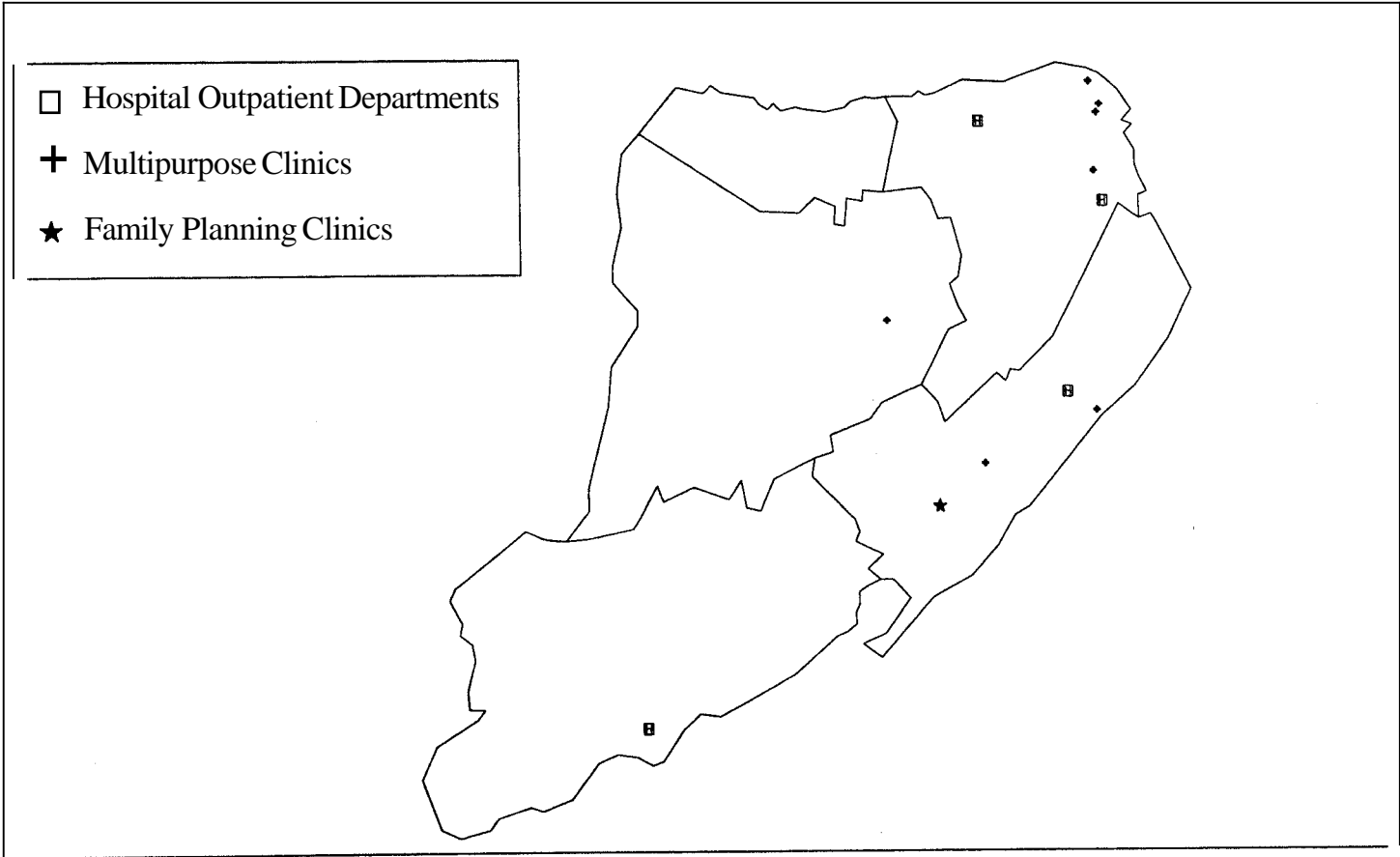
Queens, February 1995



- **Primary care facilities provide service in 13 of 18 Health Systems Agency neighborhoods in Queens.**

Primary Care Facility Sites by Health Systems Agency Neighborhood

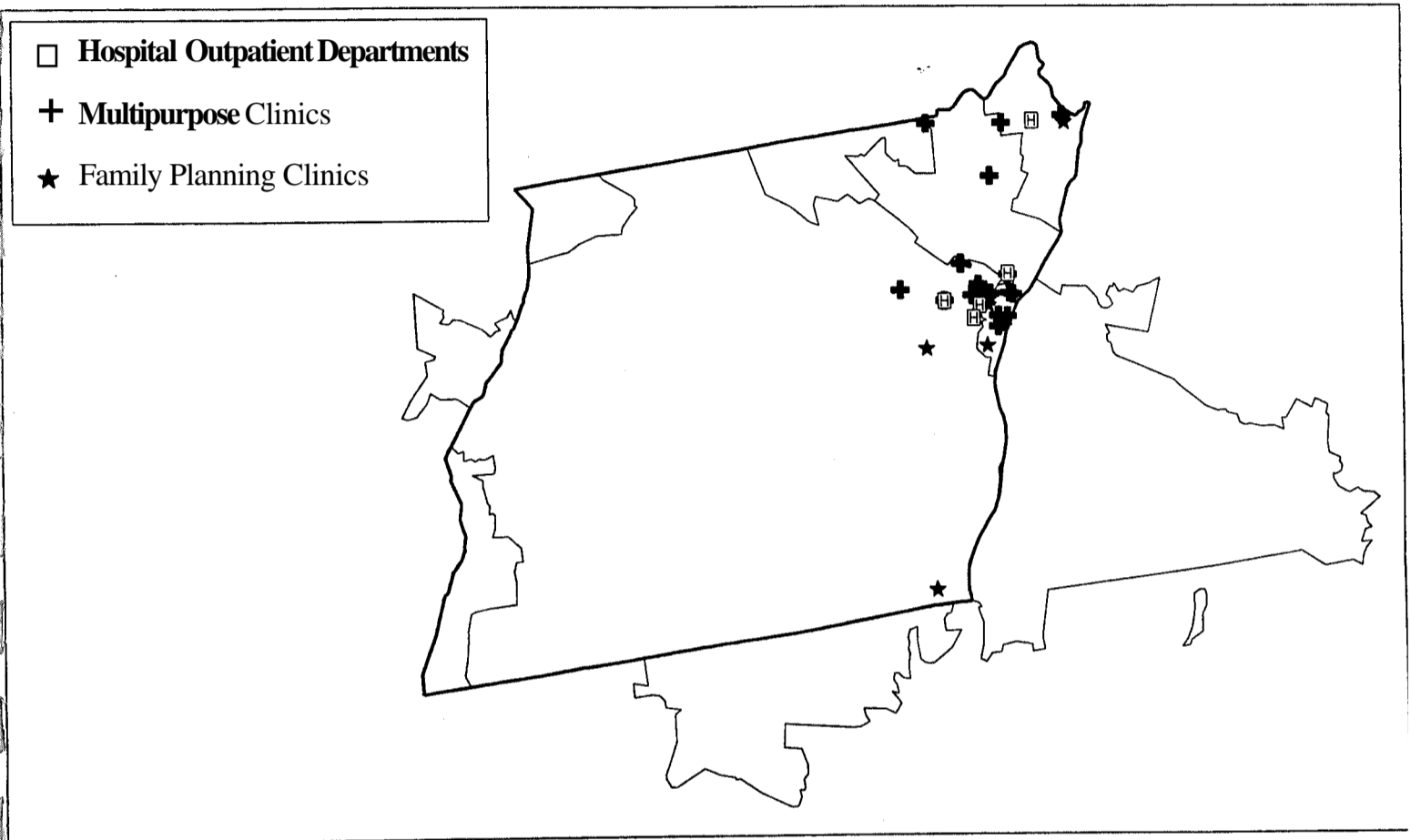
Richmond, February 1995



- **Primary care facilities provide services in 4 of 5 Health Systems Agency neighborhoods in Richmond.**

Primary Care Facility Sites by Hospital Market Area

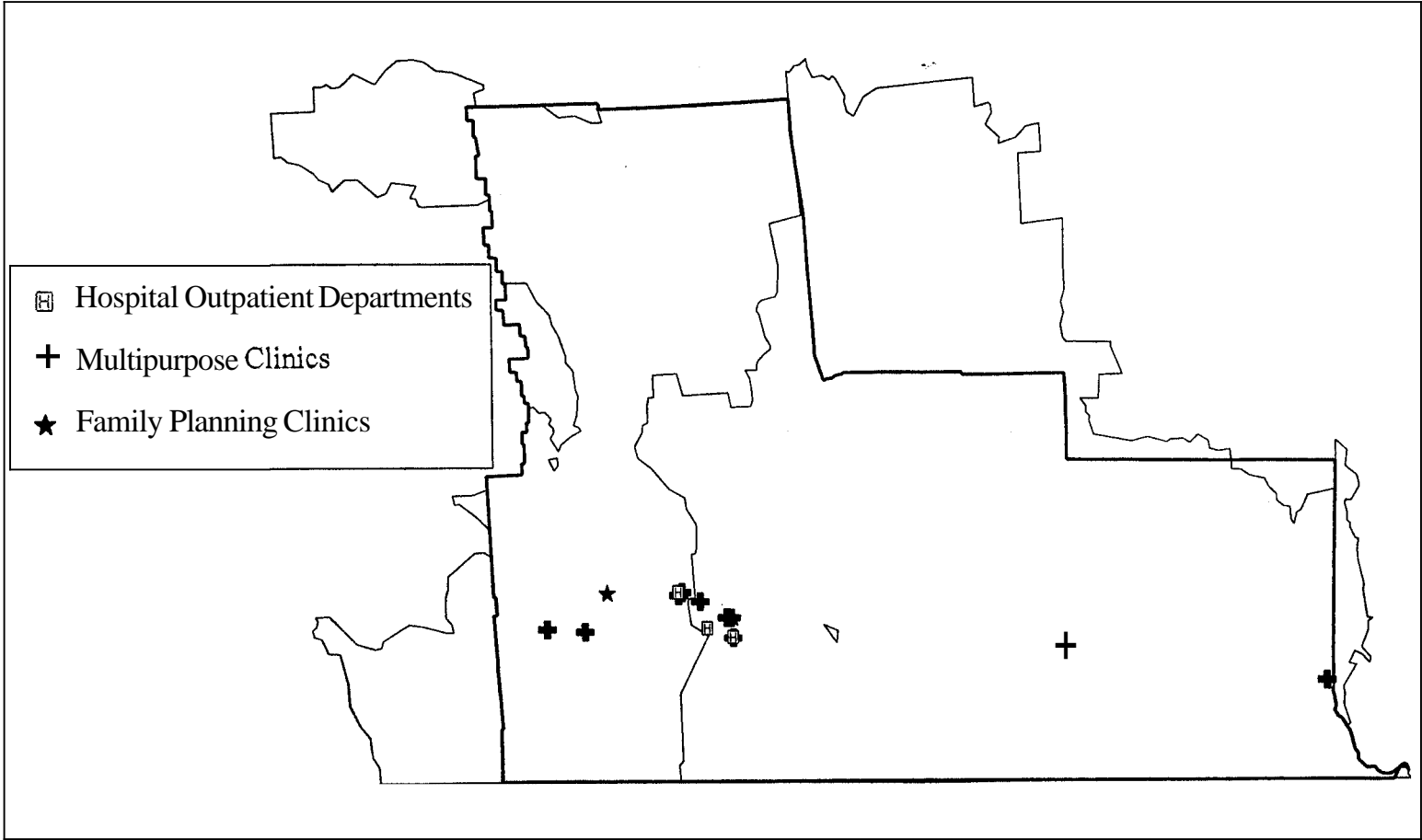
Albany County, February 1995



- Primary care facilities provide services in all 3 of the Hospital Market Areas in Albany County.

Primary Care Facility Sites by Hospital Market Area

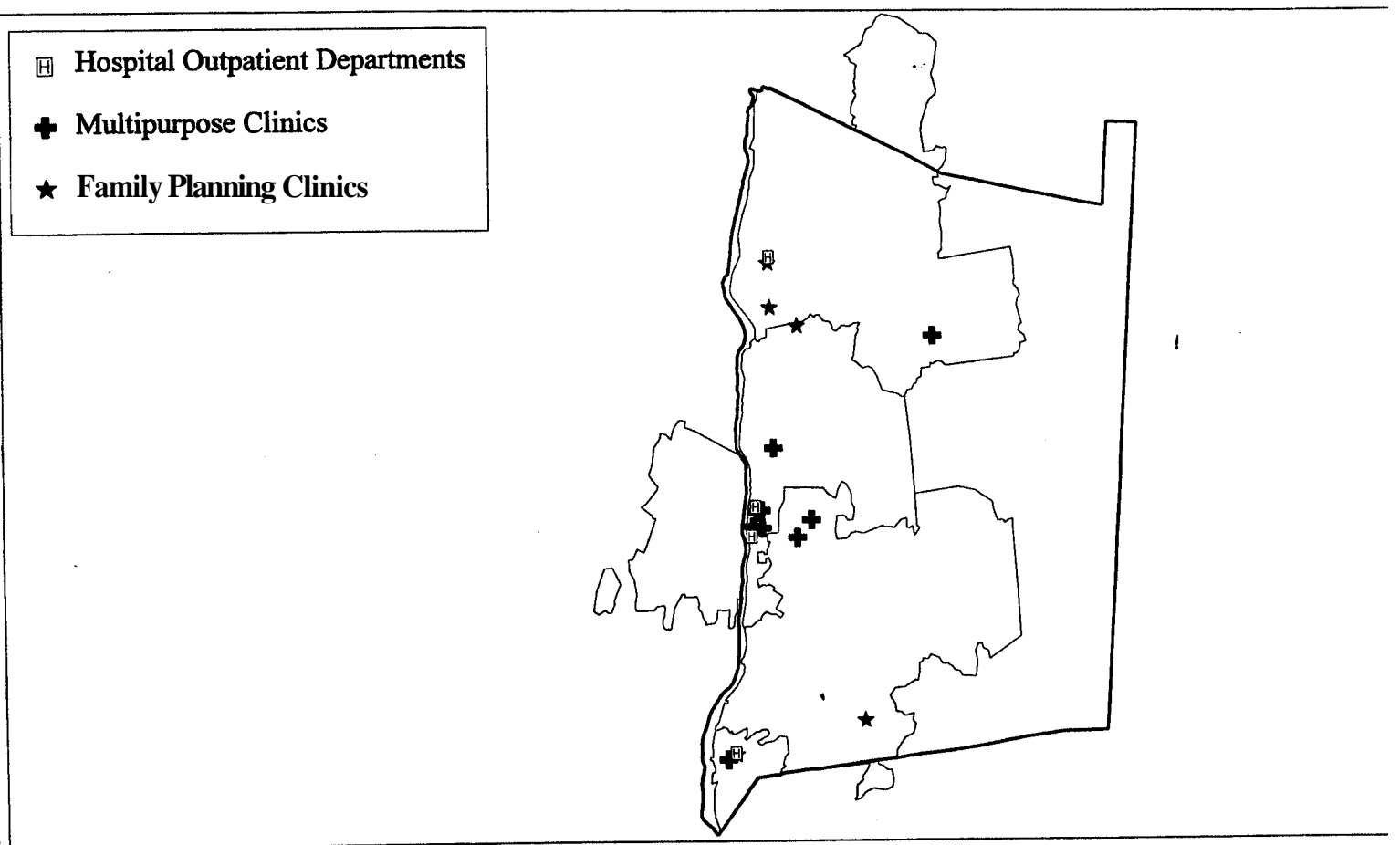
Broome County, February 1995



● Primary care facilities provide services in both of the Hospital Market Areas in Broome County.

Primary Care Facility Sites: by Hospital Market Area

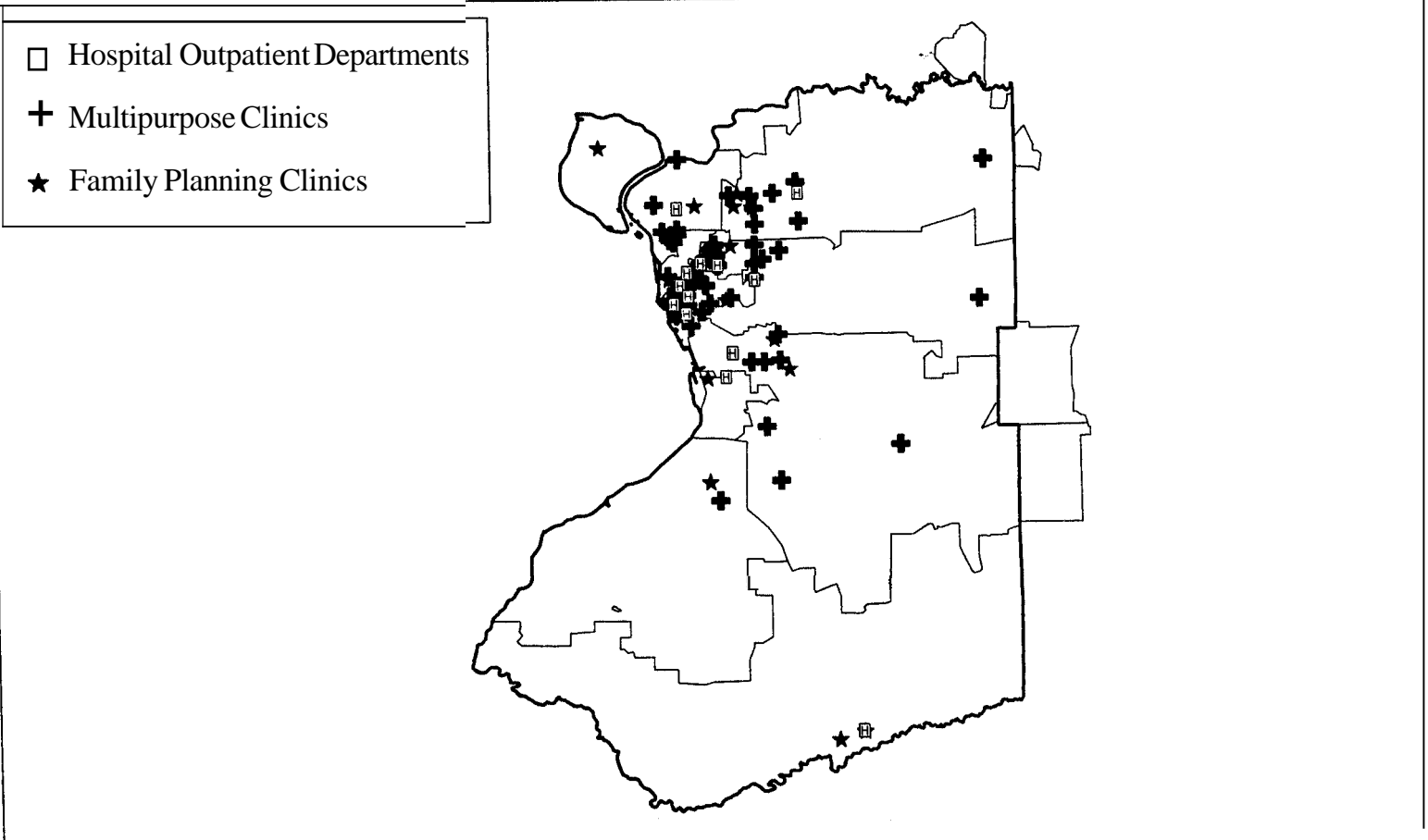
Dutchess County, February 1995



- Primary care facilities provide services in all 4 of the Hospital Market Areas in Dutchess County.

Primary Care Facility Sites by Hospital Market Area

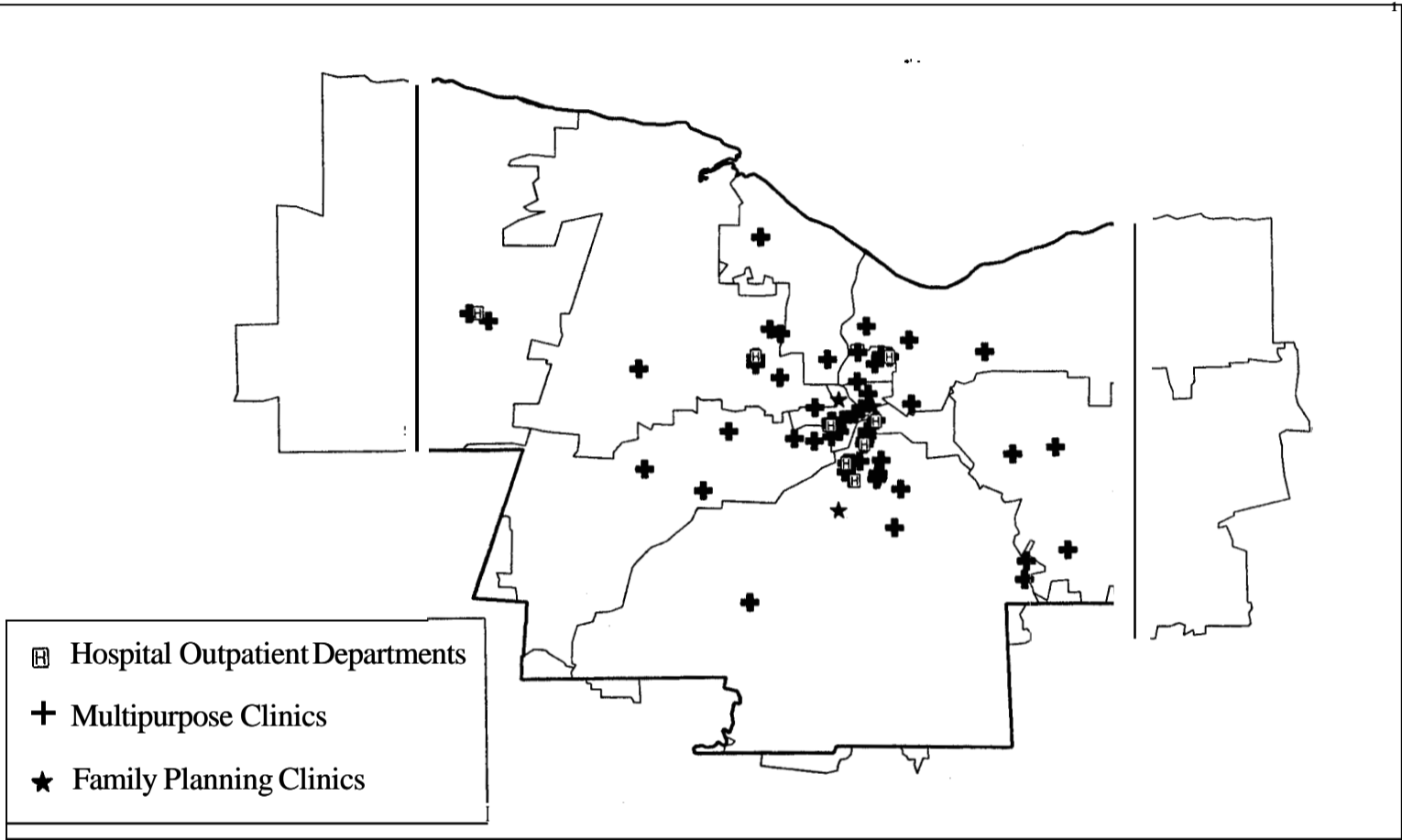
Erie County, February 1995



● Primary care facilities provide services in all 10 of the Hospital Market Areas in Erie County.

Primary Care Facility Sites by Hospital Market Area

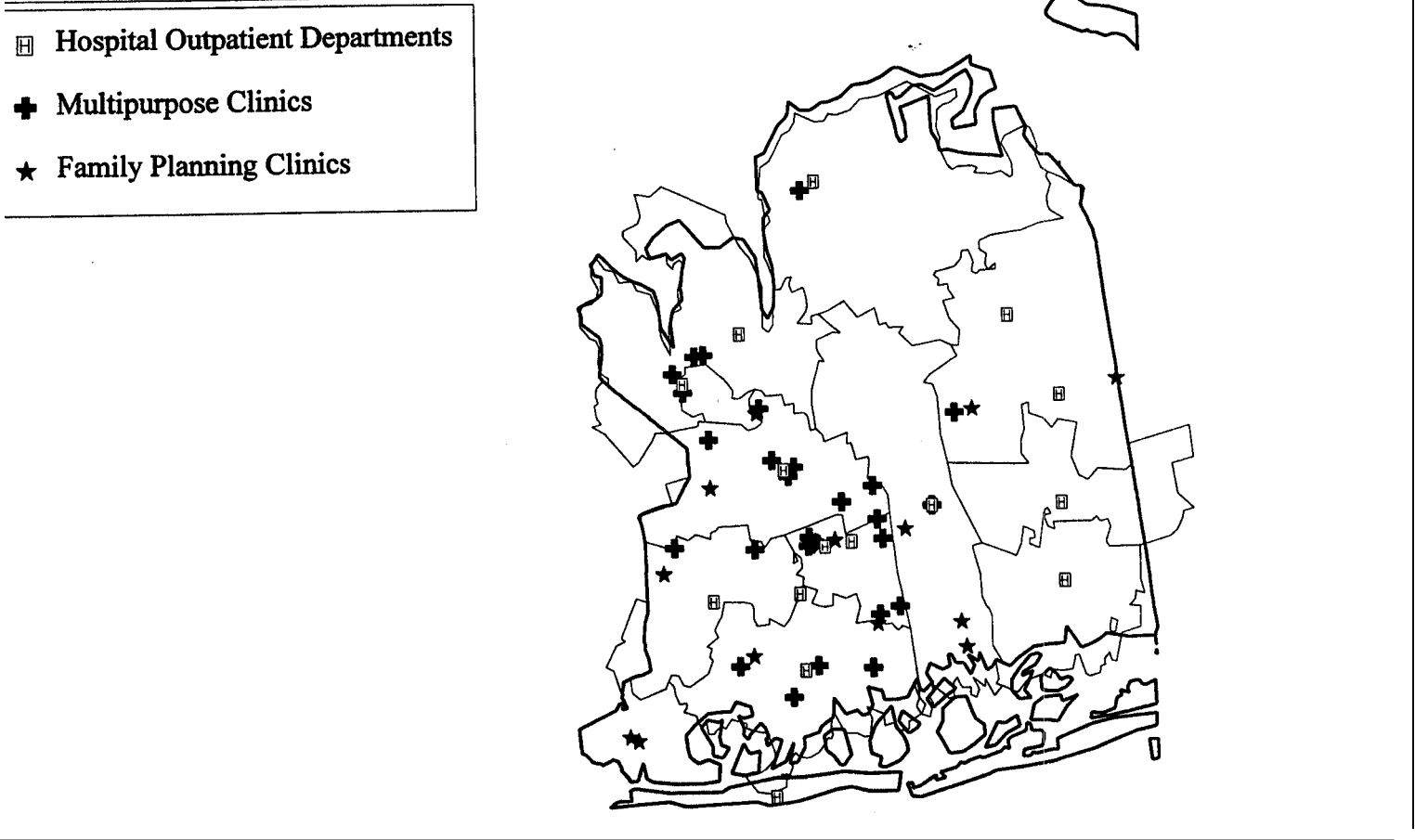
Monroe County, February 1995



● Primary care facilities provide services in all 11 of the Hospital Market Areas in Monroe County.

Primary Care Facility Sites by Hospital Market Area

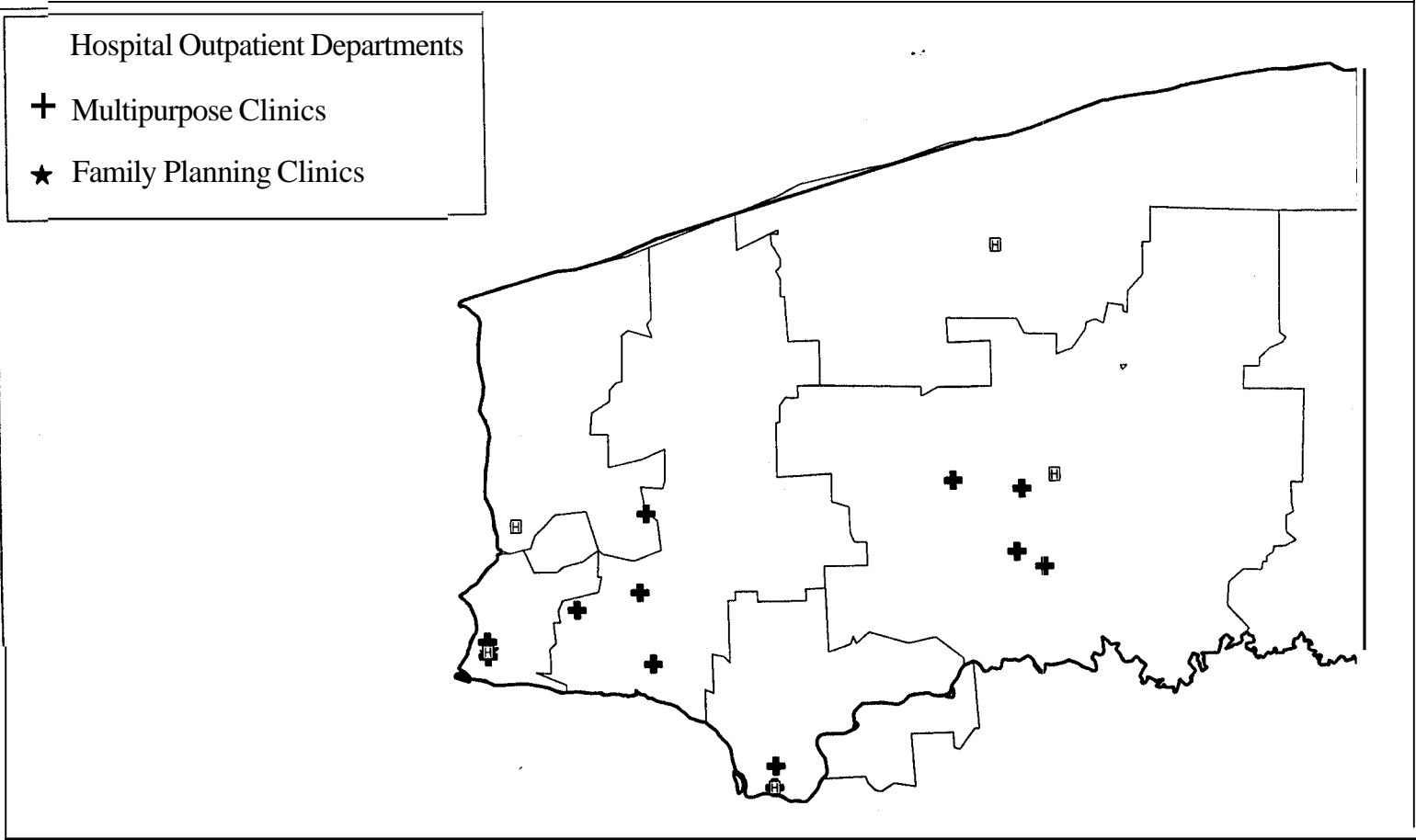
Nassau County, February 1995



- Primary care facilities provide services in all 11 of the Hospital Market Areas in Nassau County.

Primary Care Facility Sites by Hospital Market Area

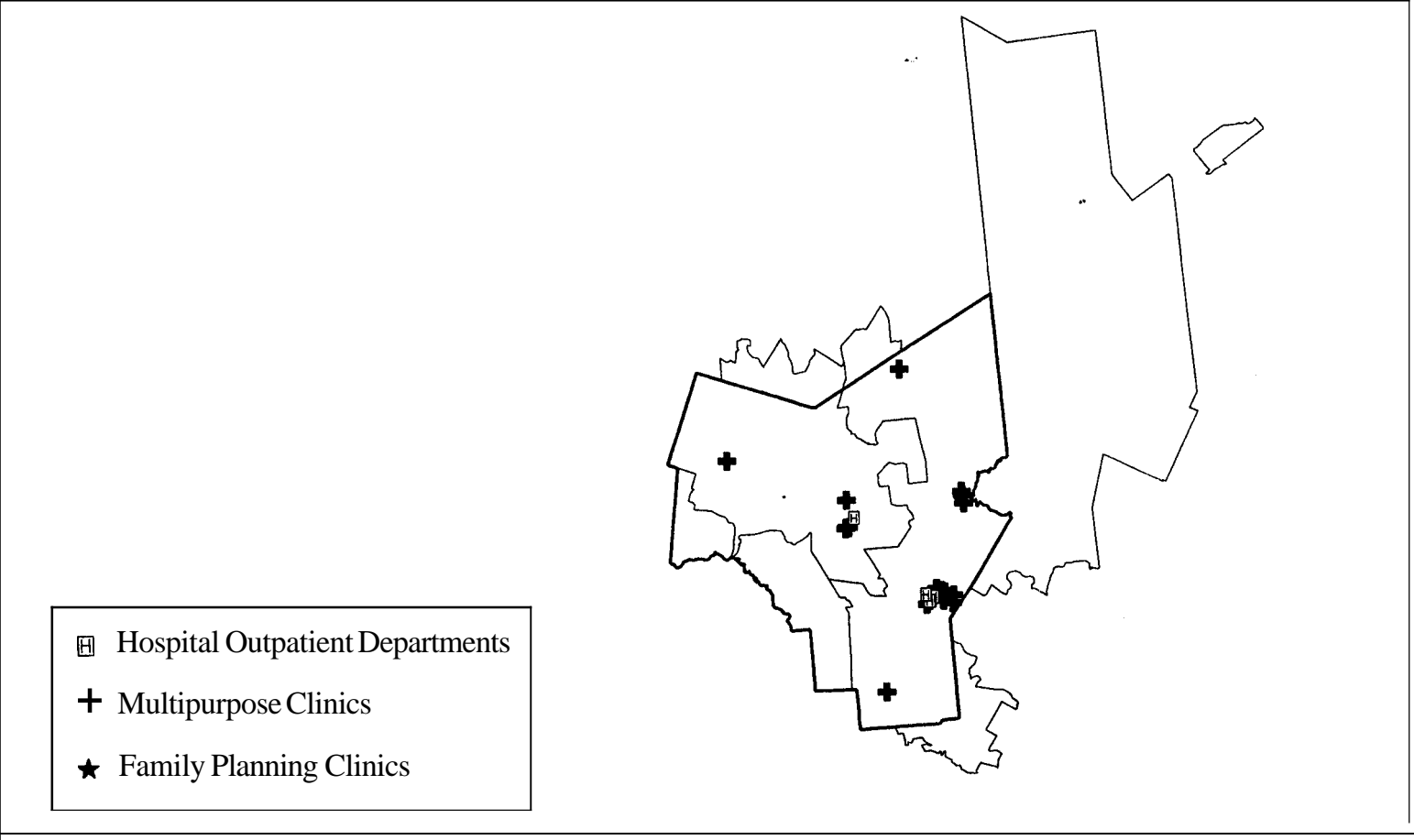
Niagara County, February 1995



● Primary care facilities provide services in all 6 of the Hospital Market Areas in Niagara County.

Primary Care Facility Sites by Hospital Market Area

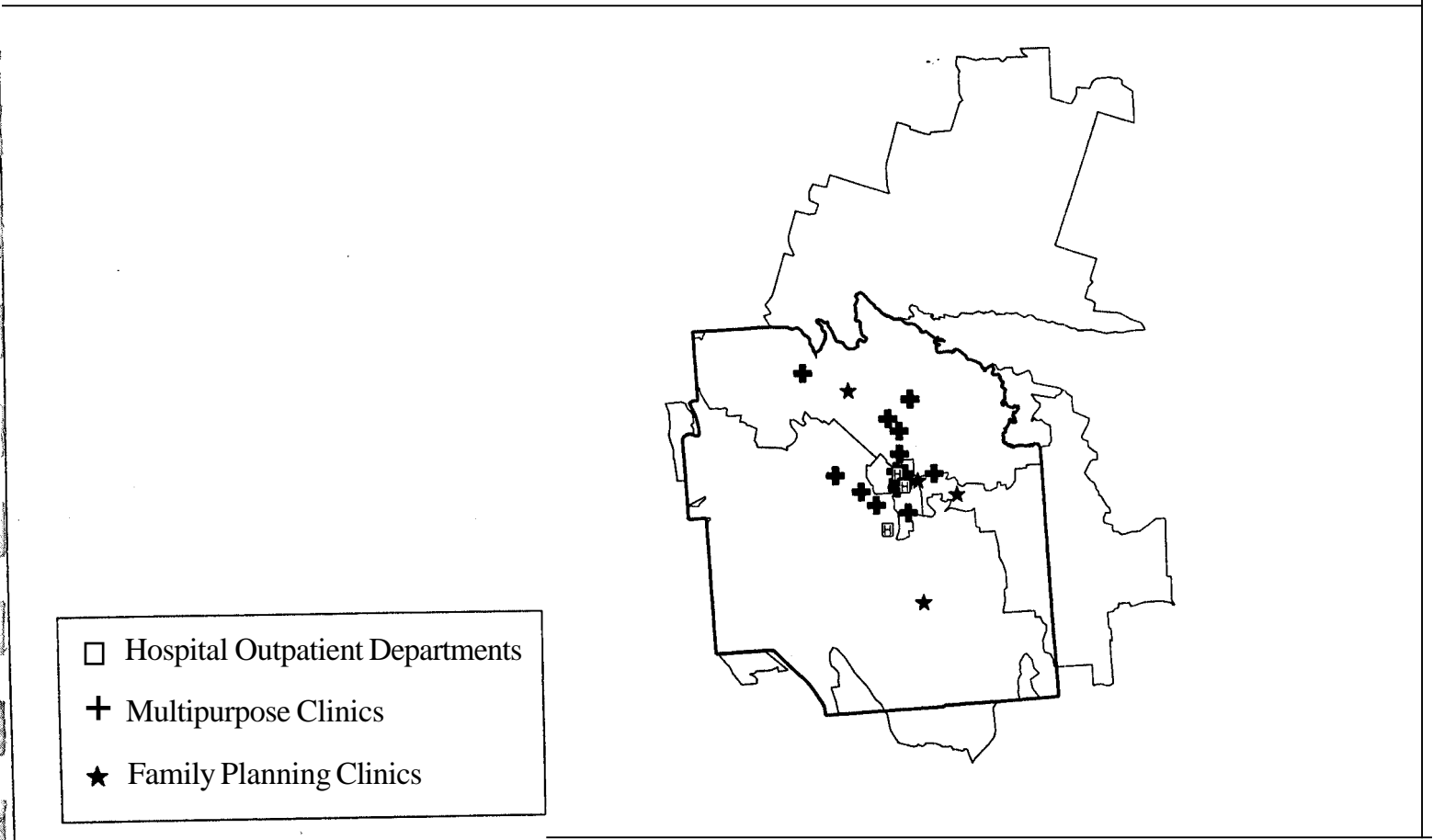
Oneida County, February 1995



● Primary care facilities provide services in both of the Hospital Market Areas in Oneida County.

Primary Case Facility Sites by Hospital Market Area

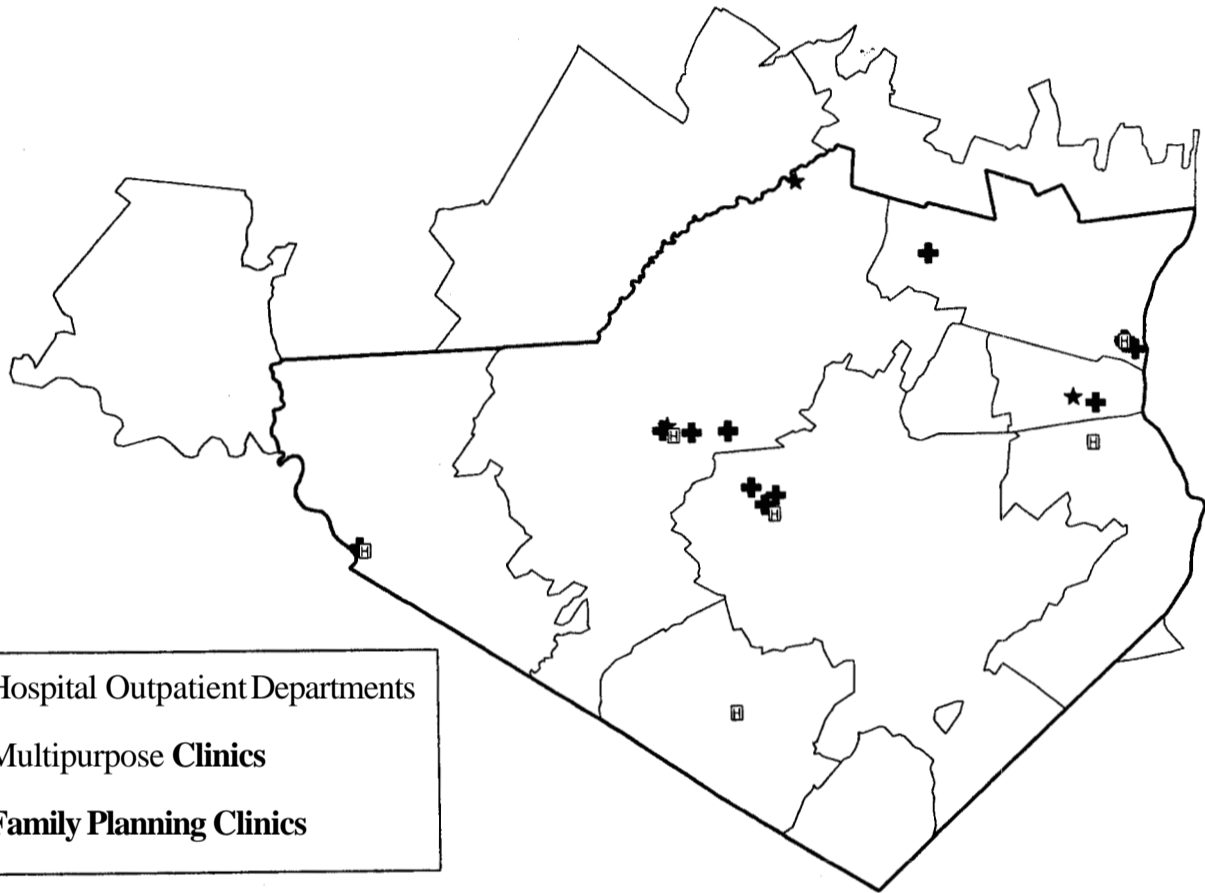
Onondaga County, February 1995



- **Primary care facilities provide services in all 4 of the Hospital Market Areas in Onondaga County.**

Primary Care Facility Sites by Hospital Market Area

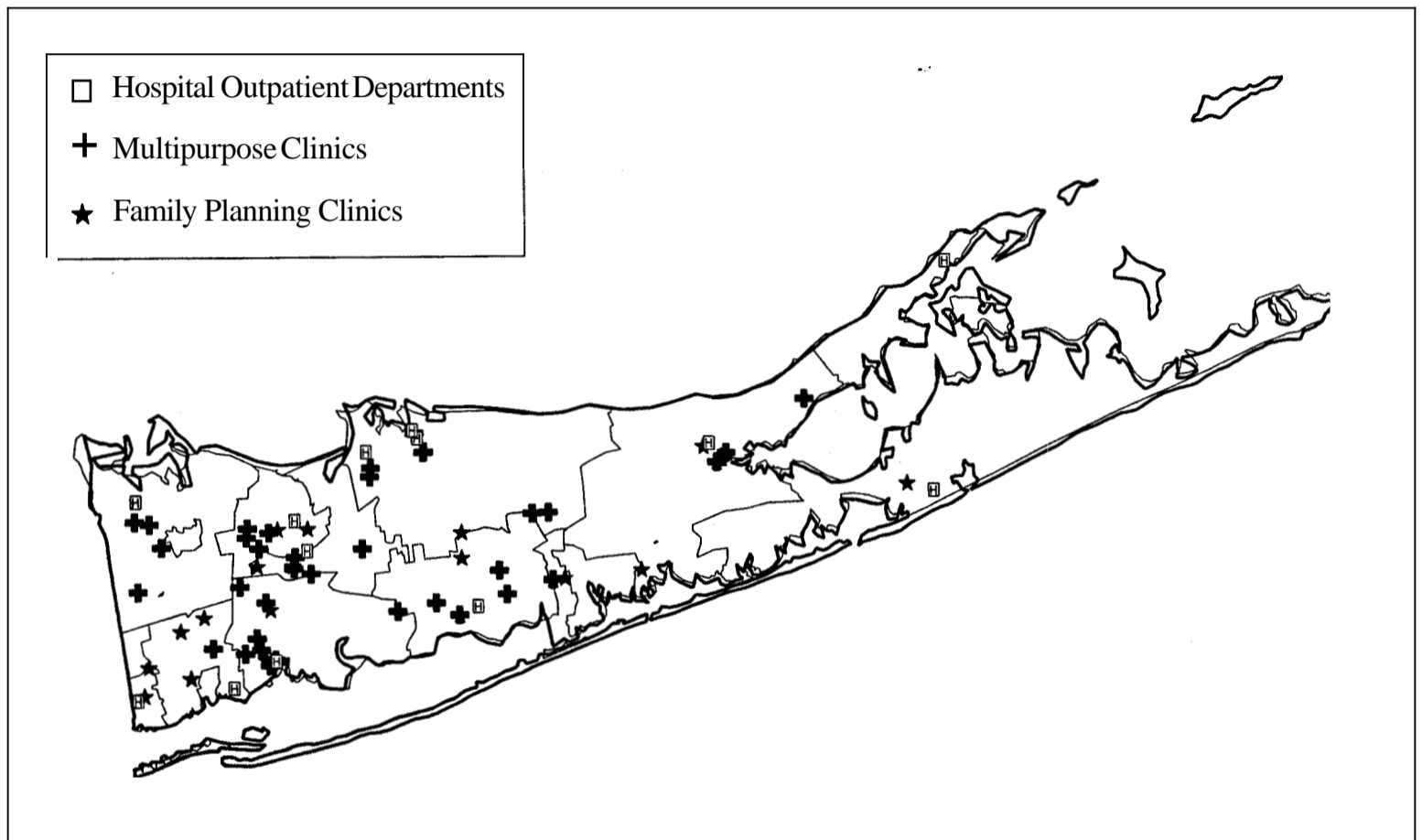
Orange County, February 1995



- Primary care facilities provide services in all 6 of the Hospital Market Areas in Orange County.

Primary Care Facility Sites by Hospital Market Area

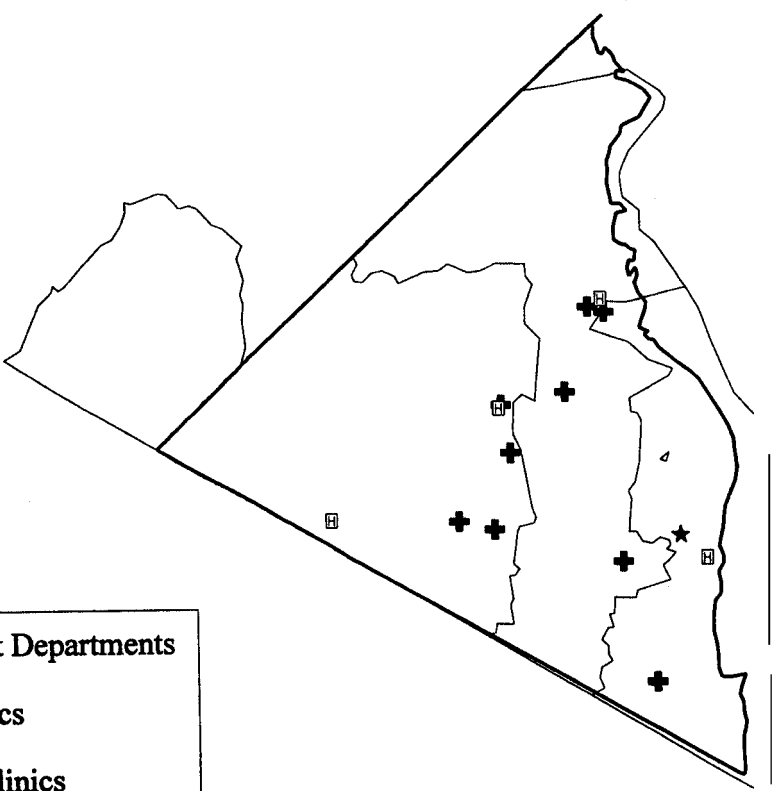
Suffolk County, February 1995



- Primary care facilities provide services in all 11 of the Hospital Market Areas in Suffolk County.

Primary Care Facility Sites by Hospital Market Area

Rockland County, February 1995



- ☐ Hospital Outpatient Departments
- ✚ Multipurpose Clinics
- ★ Family Planning Clinics

● Primary care facilities provide services in all 3 of the Hospital Market Areas in Rockland County.

Primary Care Facility Sites by Hospital Market Area

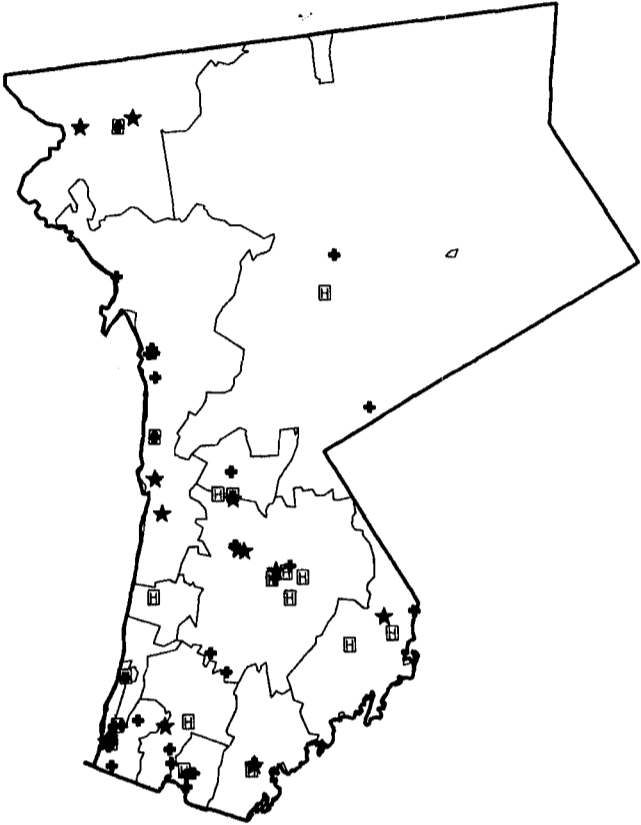
Westchester County, February 1995

- ☐

Hospital Outpatient Departments
- +

Multipurpose Clinics
- ★

Family Planning Clinics



● Primary care facilities provide services in all 11 of the Hospital Market Areas in Westchester County.

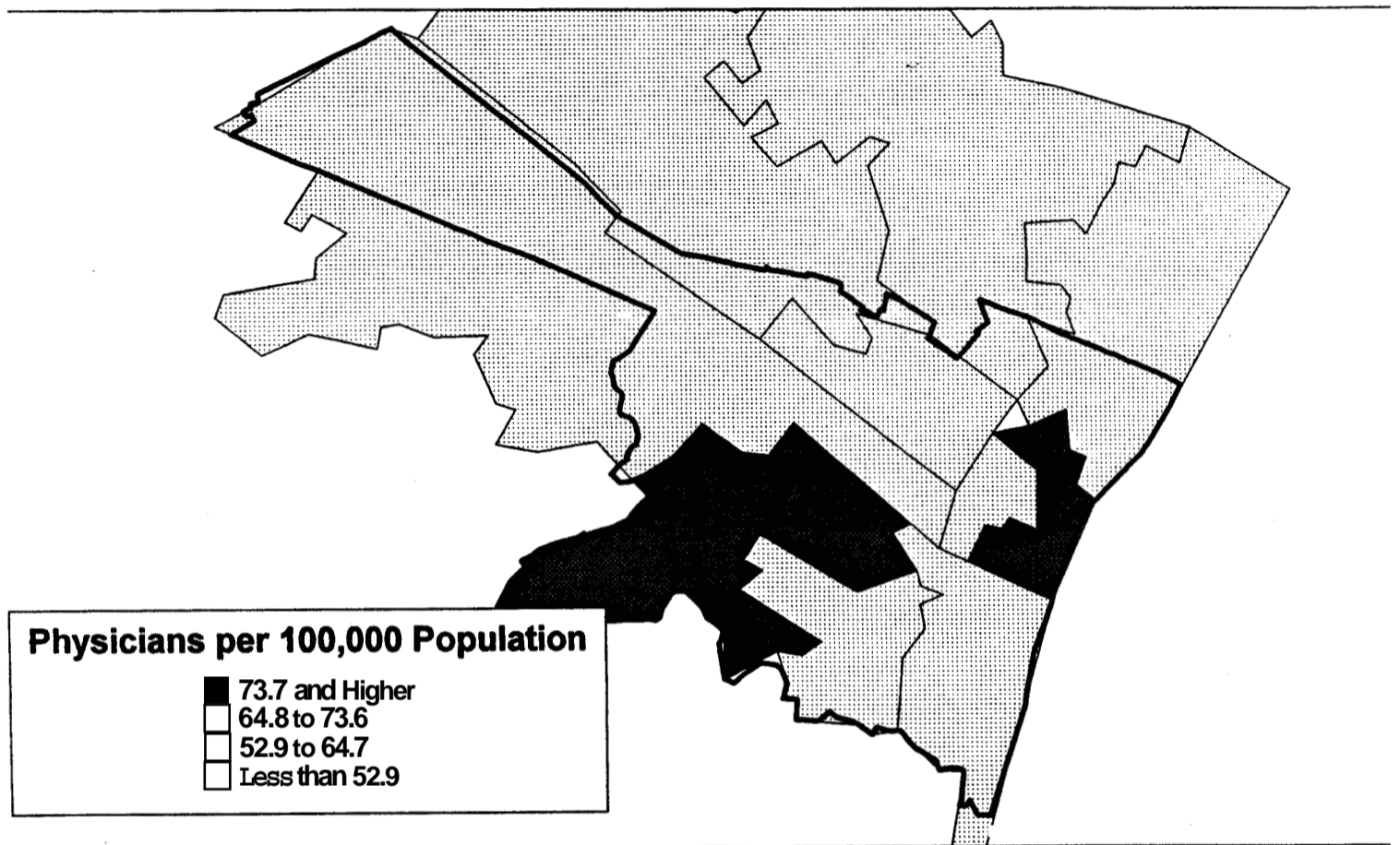
MA Eligibles Targeted for Managed Care, New York State, 1995-8
In Counties Where Physician Capacity is Adequate

	Adequate MD Capacity	Statewide	Percent of Statewide
Currently Enrolled	466,772	494,503	94%
Total Enrolled by 7/96	1,665,665	1,804,014	92%
Total Enrolled after 7/96	2,379,446	2,651,049	90%

Of the nearly **495,000** already enrolled in Medicaid managed care programs, **94** percent, ~~or~~ about **470,000**, live in counties with adequate primary **care** capacity (i.e., more than about **53** primary care physicians per 100,000). ~~Of~~ the **1.8** million to be enrolled by July **1996**, about **92** percent, ~~or~~ **1.7** million, live in counties with adequate primary care capacity.

Primary Care Physicians Per 100,000 Population by Zip Code

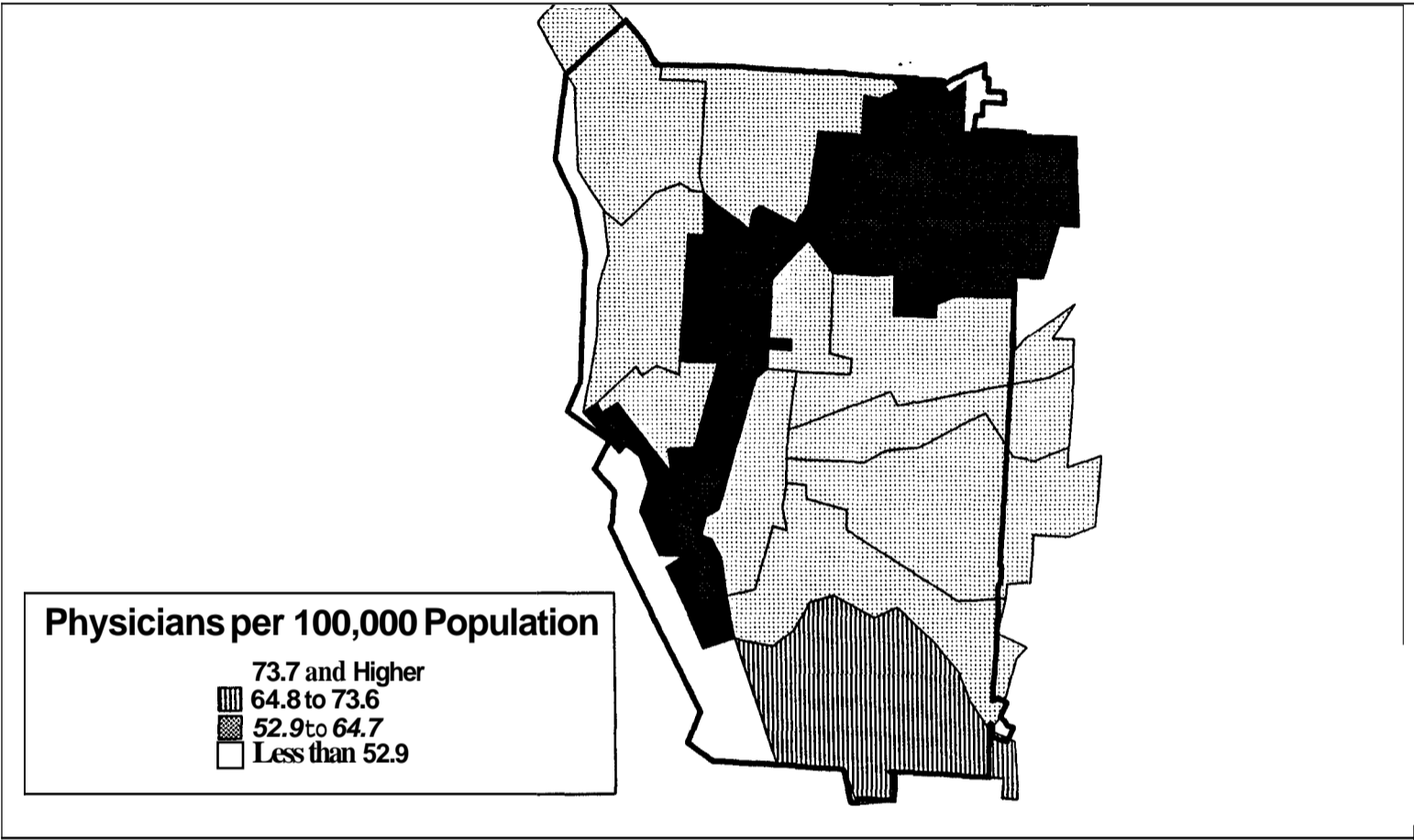
City of Albany, February 1995



- o The number of primary care physicians in Albany County per 100,000 persons is 84.2 which exceeds the New York State managed care service delivery network requirement range of 52.9 to 64.7 per 100,000.

Primary Care Physicians Per 100,000 Population by Zip Code

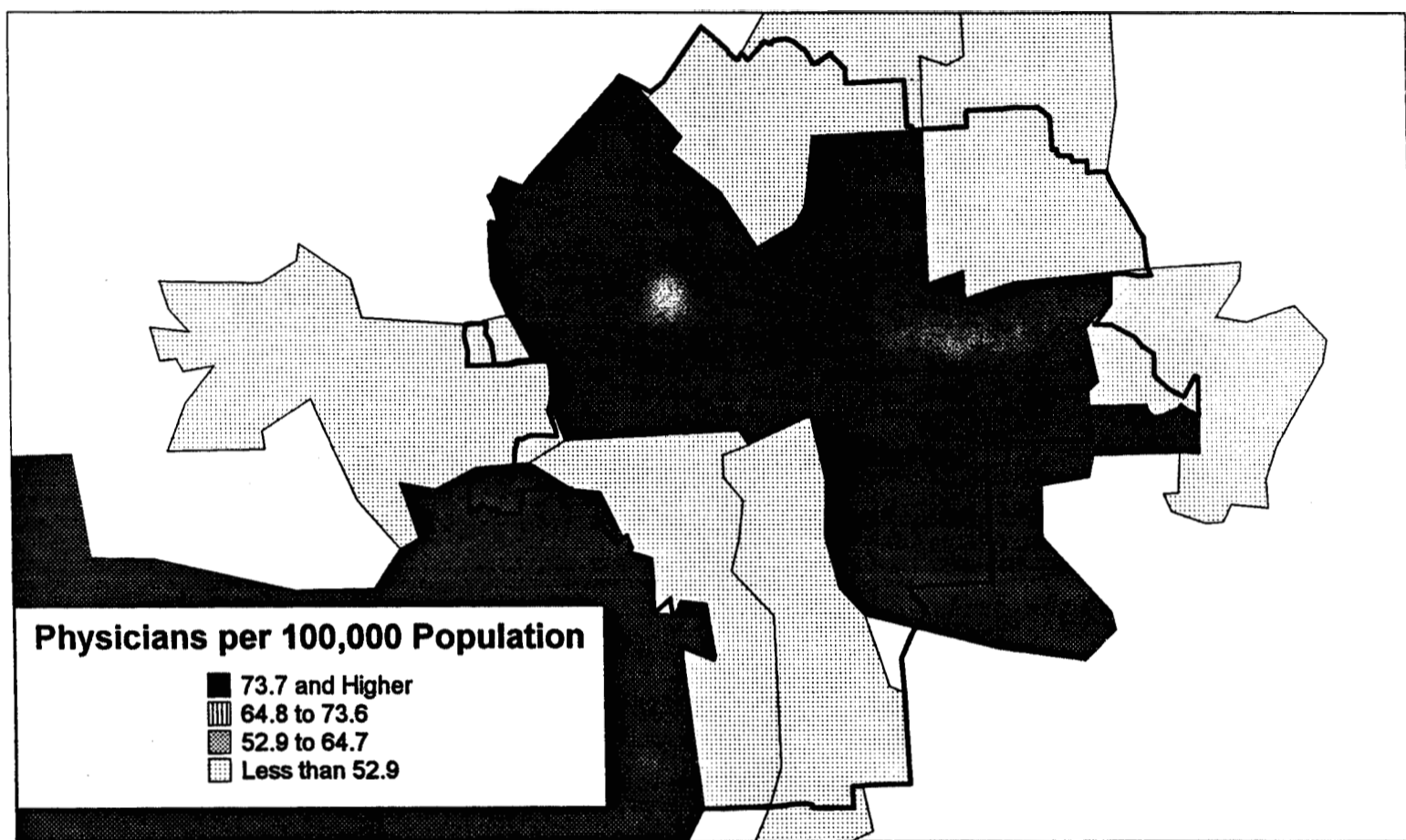
City of Buffalo, February 1995



- o The number of primary care physicians in Erie County per 100,000 persons is 63.6 which falls within the New York managed care service delivery network requirement range of 52.9 to 64.7 per 100,000.

Primary Care Physicians Per 100,000 Population by Zip Code

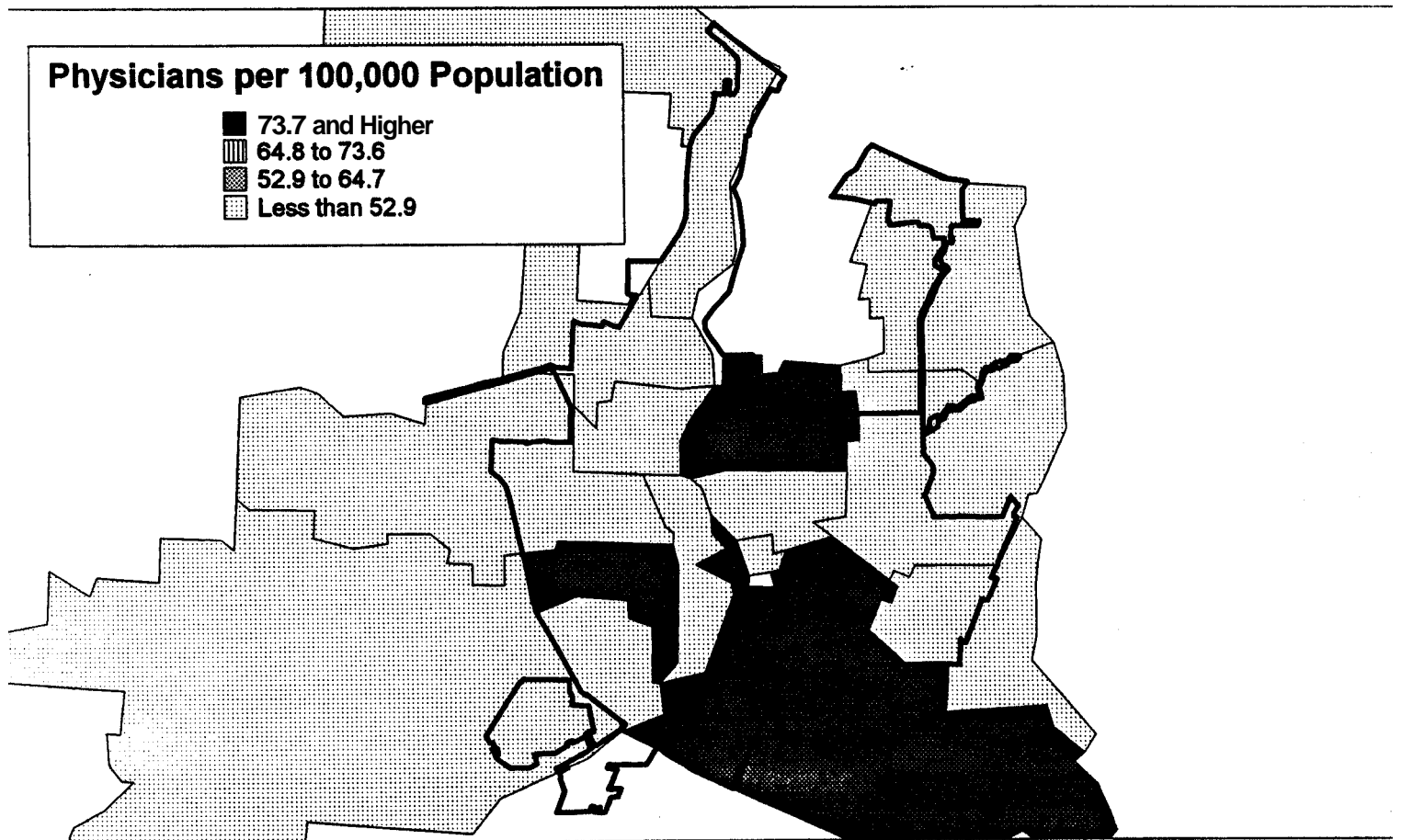
City of Syracuse, February 1995



- o The number of primary care physicians in Onondaga County per 100,000 persons is 68.1 which exceeds the New York State managed care service delivery network requirement range of 52.9 to 64.7 per 100,000.

Primary Care Physicians Per 100,000 Population by Zip Code

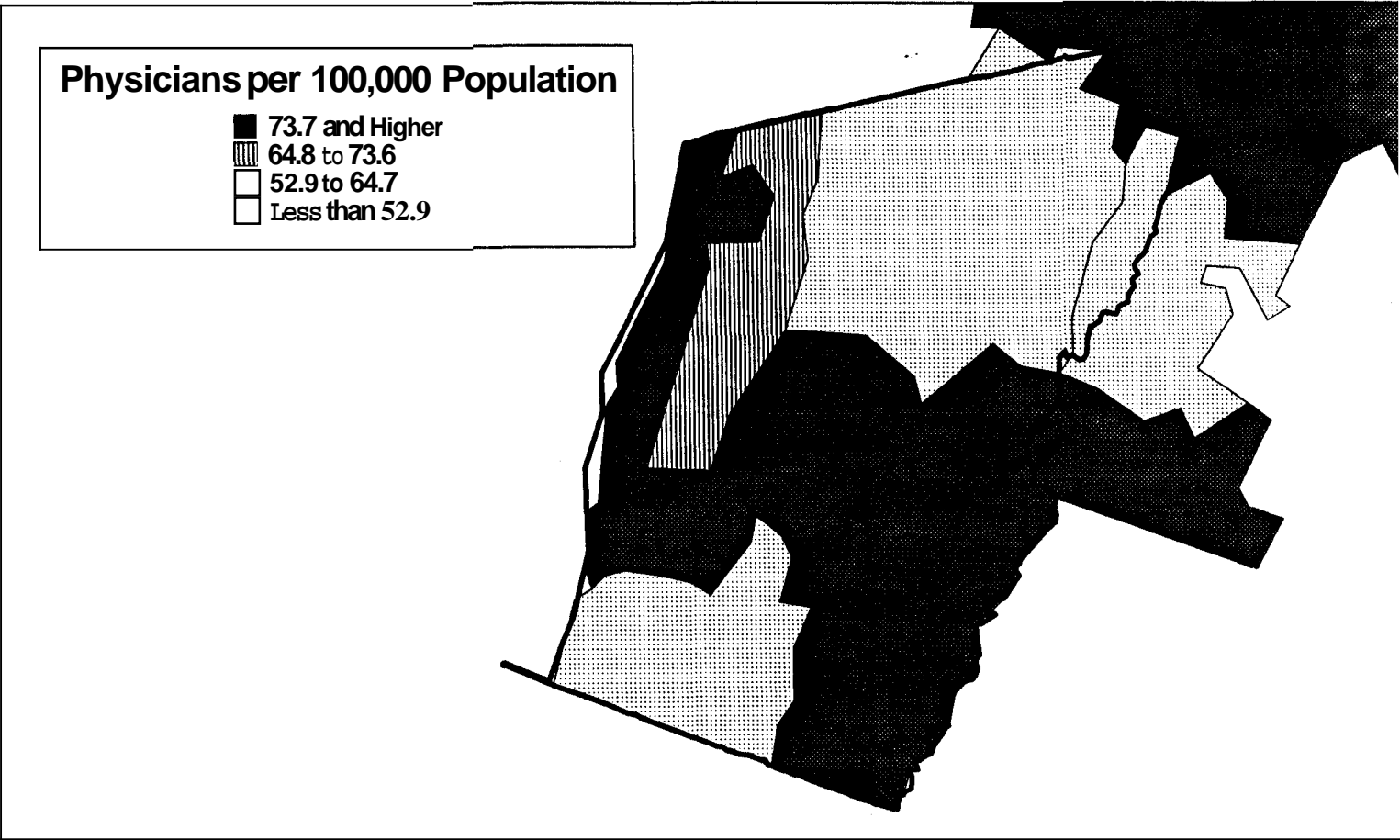
City of Rochester, February 1995



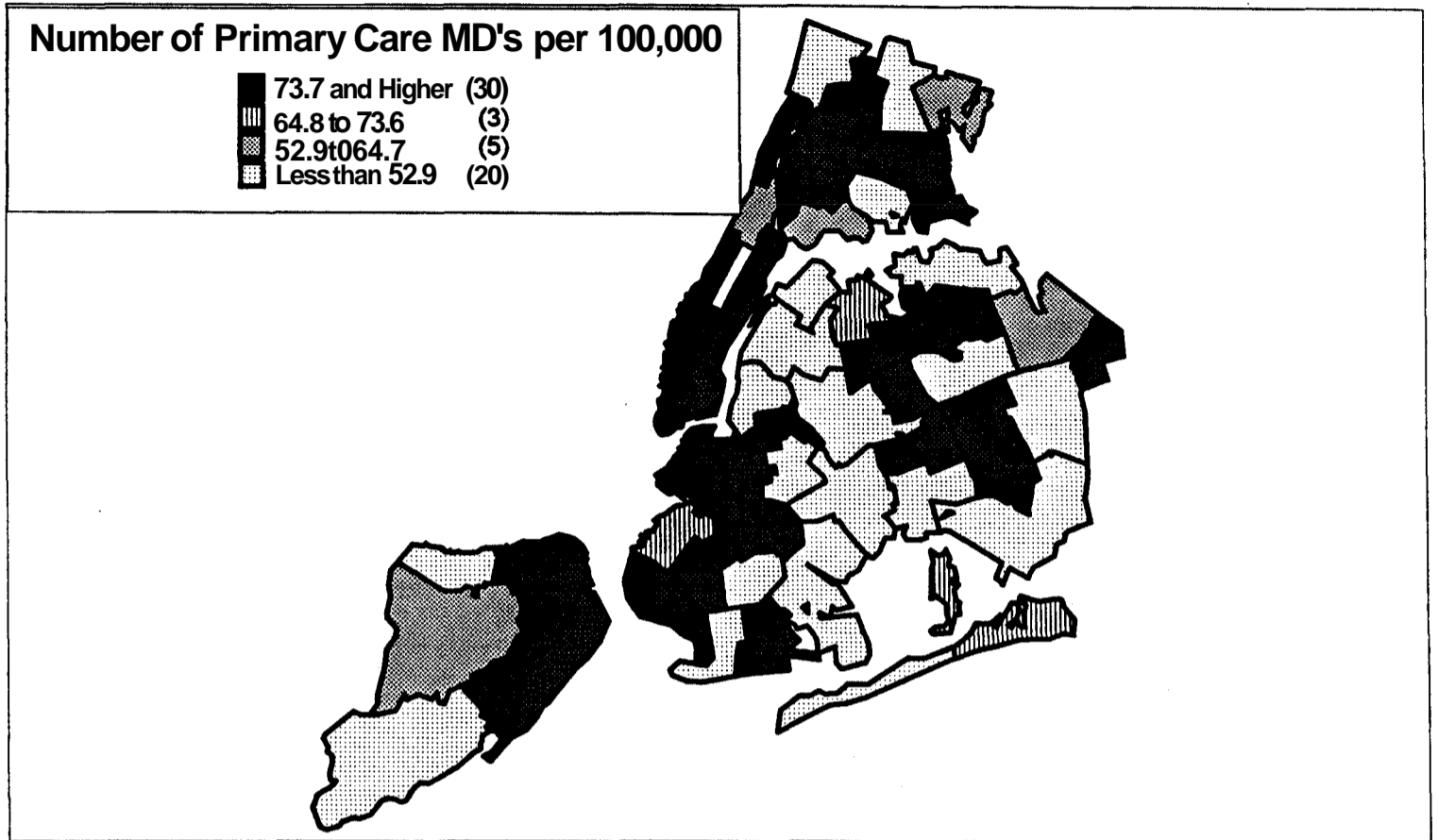
- o The number of primary care physicians in Monroe County per 100,000 persons is 75.2 which exceeds the New York State managed care service delivery network requirement range of 52.9 to 64.7 per 100,000.

Primary Care Physicians Per 100,000 Population by Zip Code

City of Yonkers, February 1995

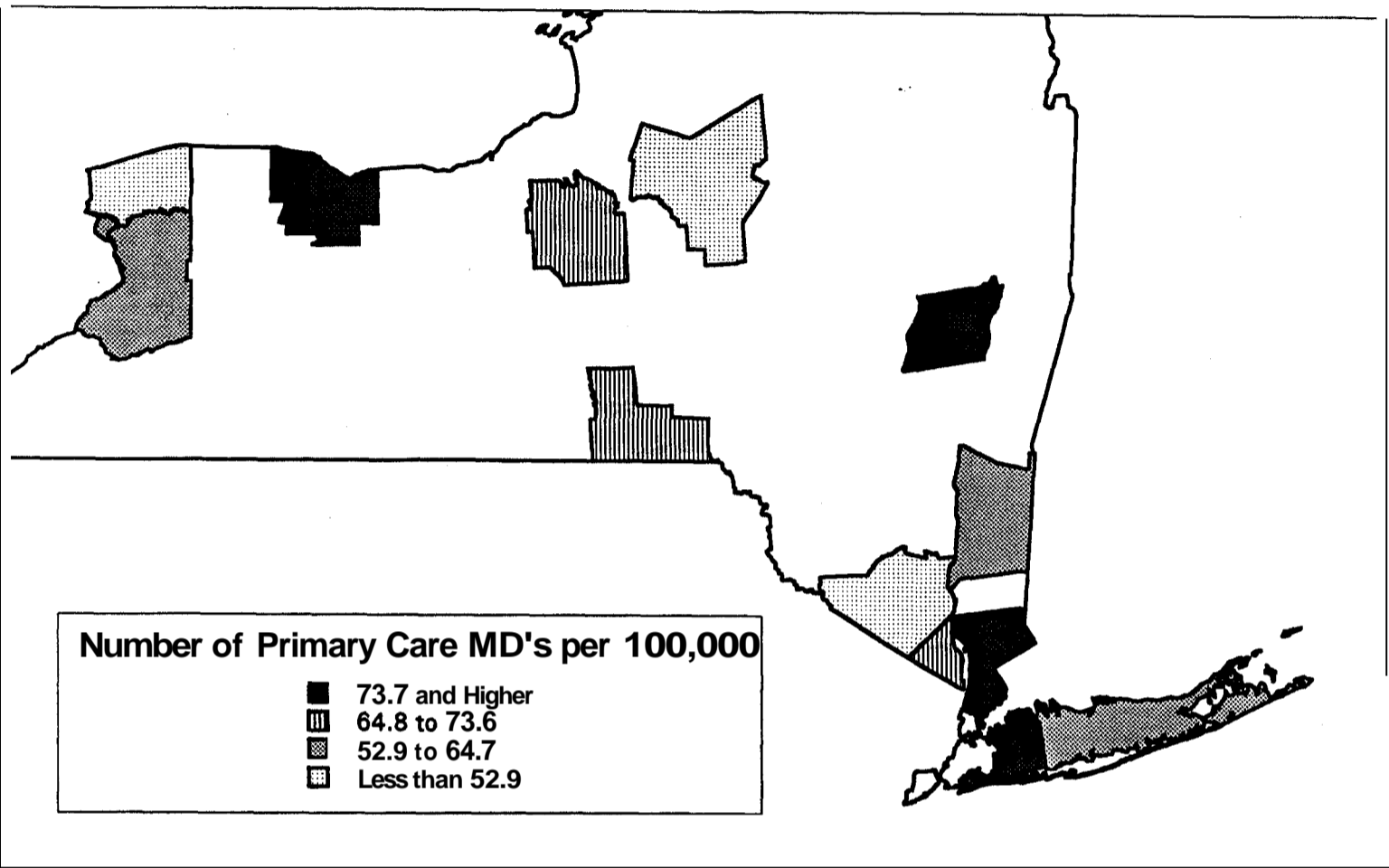


Primary Care Physicians Per 100,000 Population by Health System Agency Neighborhood New York City, February 1995



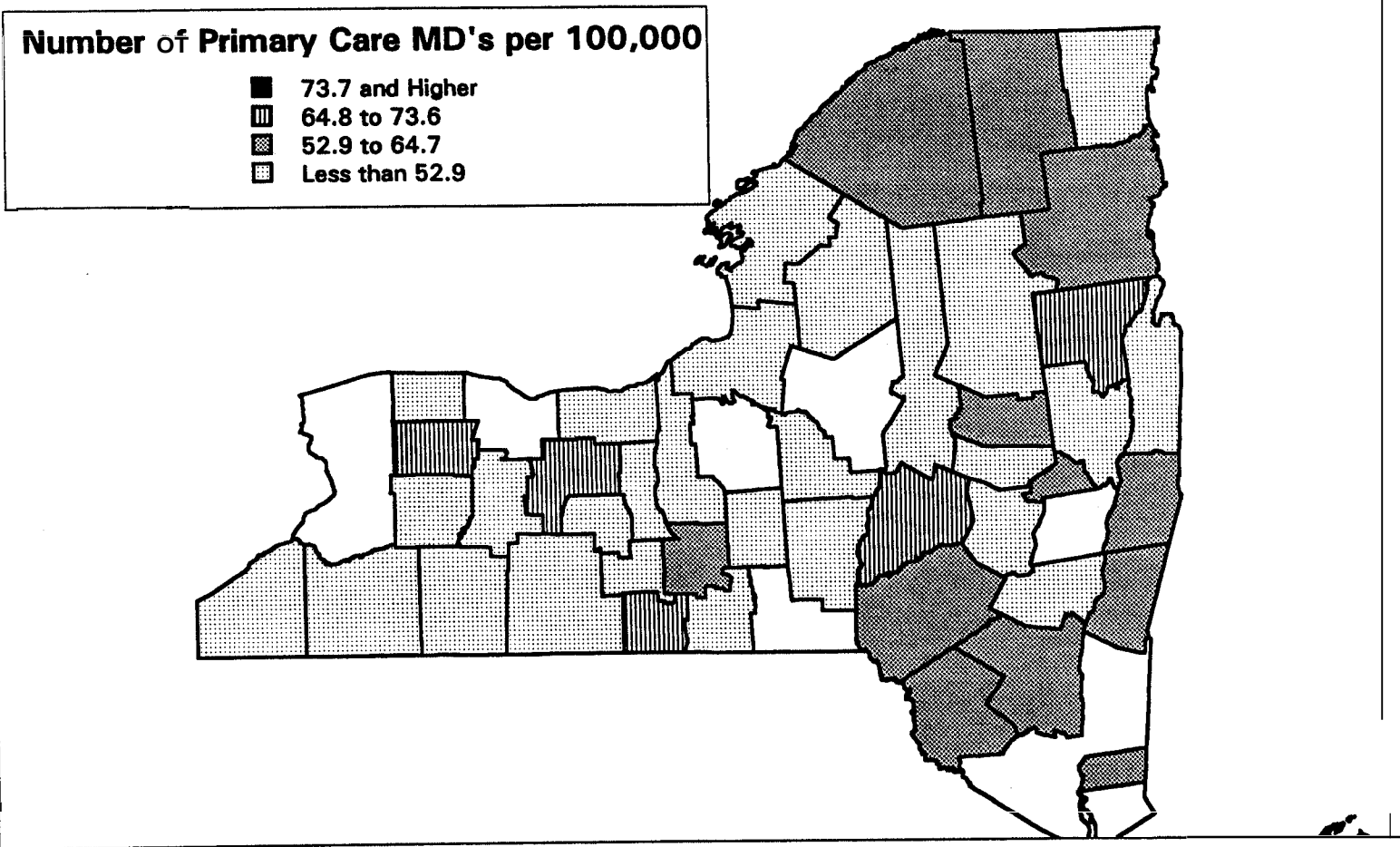
- o The New York State managed care service delivery network requirement range of **52.9** to **64.7** primary care physicians per 100,000 persons is exceeded in each of the five boroughs of New York City as follows:
 - o New York 140.5/100,000
 - o Bronx 84.0/100,000
 - o Kings 71.6/100,000
 - o Queens 64.7/100,000
 - o Richmond 73.8/100,000
- o Of the 58 neighborhoods in New York City, 38 or 66% have a physician to population ratio which meets or exceeds the New York State managed care service delivery network requirement range.
- o All of the neighborhoods that are below the managed care service delivery network requirement range are adjacent to neighborhoods which meet or exceed the range.

**Number of Primary Care MD's per 100,000
by Upstate Urban Counties**



- o Of the 13 non-New York City urban counties, 10 meet the minimum service delivery network requirement.

Number of Primary Care MD's per 100,000
by Upstate Rural Counties



- o Of the 44 rural counties, 17 meet the minimum service delivery network requirement.

**Number of Non-Physician Practitioners
By County and By Profession**

March 2, 1995

	Nurse Practitioner	Physician Assistant	County Total
ALBANY	65	103	168
ALLEGANY	11	6	17
BRONX	85	162	247
BROOME	72	23	95
CATTARAUGUS	7	5	12
CAYUGA	30	10	40
CHAUTAUQUA	14	8	22
CHEMUNG	29	8	37
CHEHANGO	13	9	22
CLINTON	19	11	30
COLUMBIA	12	19	31
CORTLAND	17	11	28
DELAWARE	6	11	17
DUTCHESS	50	41	91
ERIE	342	78	420
ESSEX	5	21	26
FRANKLIN	3	13	16
FULTON	7	4	11
GENESEE	20	11	31
GREENE	6	6	12
HAMILTON	0	2	2
HERKIMER	9	11	20
JEFFERSON	33	29	62
KINGS	131	301	432
LEWIS	1	2	3
LIVINGSTON	16	10	26
MADISON	28	22	50
MONROE	388	174	562
MONTGOMERY	8	7	15
NASSAU	186	271	457
NEW YORK	261	192	453
NIAGARA	36	8	44
ONEIDA	106	26	132
ONONDAGA	328	66	394
ONTARIO	35	21	56
ORANGE	47	20	67
ORLEANS	4	3	7
OSWEGO	42	7	49
OTSEGO	22	30	52
PUTNAM	21	9	30
QUEENS	112	286	398
RENSSELAER	25	37	62
RICHMOND	36	107	143
ROCKLAND	52	23	75
ST. LAWRENCE	40	21	61
SARATOGA	35	60	95
SCHENECTADY	33	58	91
SCHOHARIE	6	8	14
SCHUYLER	2	4	6
SENECA	1	10	11
STEUBEN	20	18	38
SUFFOLK	438	264	702
SULLIVAN	9	7	16
TIOGA	17	4	21
TOMPKINS	40	17	57
ULSTER	24	33	57
WARREN	9	26	35
WASHINGTON	5	10	15
WAYNE	25	17	42
WESTCHESIER	215	143	358
WYOMING	9	6	15
YATES	11	1	12
STATE TOTAL	3679	2931	6610

NEW YORK STATE RURAL HEALTH NETWORK PROGRAM

A STRATEGY TO IMPLEMENT MANAGED CARE IN RURAL NEW YORK

The federal section 1115 waiver for increasing Medicaid enrollments in managed care creates a significant challenge for most rural areas. Based on the waiver concept paper, 12 of New York's 44 rural counties may meet the criteria for exemptions from enrolling their Medicaid eligibles in fully capitated managed care plans and an additional thirteen others have primary care physician to population ratios of less than 45 per 100,000 (e.g. significantly lower than the New York State-specified Medicaid managed care service delivery network requirement range of 53 to 65) (see attached table).

The State's strategy to increase enrollment levels in Medicaid managed care in rural areas will be to facilitate the efforts of counties to identify local providers and managed care plans in which Medicaid recipients can be enrolled. This facilitation will be accomplished by helping to convene appropriate state and local interest groups that individually or in collaboration have the capacity to develop or participate in managed care plans. Facilitation will also be provided through direct technical assistance by helping complete risk analyses, initiating start-up and setting up needed monitoring and information systems. To the extent possible, the strategy will give priority to the development of managed care capacities through locally organized networks to enable maximum maintenance of local direction (governance) and operation of rural health care delivery systems. **The strategy will be completed within a two year period and will result in 32 counties achieving targeted enrollment levels through fully capitated managed care programs and 12 counties achieving targeted enrollments through partial capitation or physician case management approaches.** During the first year under the 1115 waiver the State's efforts will be targeted on 32 rural counties 23 of which are participating in the 17 networks funded under the Department of Health's Rural Health Network Development Program. The second year will expand efforts into the remaining 12 smaller rural counties.

The strategy will build on the current efforts of the Department of Health and its Rural Health Council to respond to the challenges facing rural communities and providers. The Department and Council are pursuing a multi-faceted agenda to promote the formation and operation of rural health networks. One aspect of this agenda is to foster the development of finance and reimbursement approaches that will better support the operation of integrated health care delivery systems that have a capacity to participate in managed care systems. As a starting point for implementing a rural Medicaid managed care enrollment strategy, the Rural Health Council, at its February 9, 1995 meeting, formally endorsed this direction and conveyed their interest in playing a role to achieve greater levels of managed care in rural areas to Commissioner DeBuono.

The first step of the strategy will be to modify the overall goals of the Department's Rural Health Network Development Program to include a specific focus on the development of Medicaid managed care capacities. This new priority will be communicated to all current contractors under the network program at the time of submission of the 1115 waiver and all future contracts will require that the networks place greater emphasis on increasing Medicaid

managed care capacities within their service areas. All current contracts will be up for renewal by October 1, 1995.

The Department of Health, through its Office of Rural Health, and in conjunction with the Rural Health Council will seek the voluntary participation of managed care plans, provider associations, employers, labor, county governments, networks and other private and public sector interest groups in this effort. The State level component of the strategy will entail convening a series of statewide meetings during April, May and June to enroll interested parties in helping to achieve the Medicaid managed care goals in rural areas. At a minimum this will involve the New York State Medical Society, the Healthcare Association of New York State, the Community Health Care Association of New York State, the New York State Association of County Health Officers, the New York State Business Council, the State HMO Conference, the New York Conference of Blue Cross and Blue Shield Plans, and all managed care plans currently serving Medicaid recipients in New York State. Interested groups will be requested to assist in designing a more targeted effort in the 32 selected rural counties of the state during the months of July and August. This will be followed by a series of information sessions co-sponsored by the State and County Departments of Social Services during August and September with the 17 networks (covering 23 of the target counties), as well as the nine other rural counties targeted for increasing enrollment in full capitation managed care plans. These sessions will serve to describe the extent of interest and technical assistance that will be made available to networks and counties to help them develop increased capacities for enrolling Medicaid clients in managed care programs.

The Department of Health's Rural Health Network Development Initiative provides \$1.0 million annually in grant funding to support the planning and implementation of networks. Seventeen grant awards have been made to rural communities and providers in Upstate New York to assist them in their efforts to improve access to a range of quality health care services (see attached map). The grants support activities in twenty-three of New York's rural counties and serve over two million residents (see attached map). The grant recipients are developing and implementing rural health networks that will help rural communities to maintain local health care. Network provider participants vary from network to network, but in general they include hospitals, emergency medical services, primary care providers including community health centers, rural health clinics or federally qualified health centers and local public health agencies. We believe these networks offer a natural venue for the Department as it moves to implement Medicaid Managed Care programs throughout rural New York. These 23 counties have almost 160,000 Medicaid eligibles of which 16,300 (10.2 percent) are enrolled in full capitation managed care plans. The 1115 waiver has targeted enrollment levels in these counties to increase to 78,700 requiring increased enrollment of 62,400.

The local component of the strategy to increase the enrollment of Medicaid clients in managed care will involve two approaches. In the eleven network counties that must enroll their Medicaid population in fully capitated plans, participating providers in the networks will be encouraged to work with the existing or other identified managed care plans to identify

strategies for increasing enrollment levels. This may involve the network entering into an arrangement with one or more managed care plans, if they are sufficiently organized to do **so** or it may involve some of its participating providers entering into individual agreements with the plans. This approach will also be pursued in the eight other counties that are not involved in the Department's Network Program that must enroll their Medicaid recipients in full capitation plans. The second approach will involve those network counties that may meet the criteria for exemption from the full capitation requirement of the **1115** waiver. To the extent possible, these counties and their participating providers will first be encouraged to work with existing or other identified managed care plans to increase enrollment levels in full capitation plans. However, in those instances where this is not feasible, direct technical assistance will be provided to help the network, if it is sufficiently organized or if not, its individual providers, to enter into partial capitation or physician case management arrangements to increase enrollment levels. The main focus of the technical assistance will be on assessing the level of risk being assumed by the networks and/or their providers and designing capacities to minimize that risk.

This strategy will require the development of a state level multi-agency task force that is dedicated to providing direct technical assistance to rural communities and providers. Staff from the Departments of Health, Social Services, Office of Mental Health, Office of Mental Retardation and Developmental Disabilities and Office of Alcohol and Substance Abuse Services will need to be assigned responsibilities for working **as** part of a state technical assistance **team**. In addition, it will require dedicated funding to support the continued development of networks that have the capacity to provide managed care. During year one, the existing Rural Health Network Development **Program** will provide sufficient support for efforts targeted at the first **17** sites. However, since the network program will sunset with NYPHRM V, in year two a dedicated funding source will need to be identified.

Medicaid Managed Care in Rural Counties of New York State

Full Capitation Medicaid Managed Care Counties

County	Medicaid Eligible'	Medicaid Enrolled in Managed Care*	Percent Enrolled in Medicaid Managed Care	Percent Total HMO Penetration **	Section 1115 Waiver Target***
Cattaraugus'	10159	0	0.00%	25%	4680
Chautauqua'	20997	940	4.40%	12%	9827
Chenango'	6302	0	0.00%	12%	2902
Clinton	9045	1005	11.11%	15%	4142
Columbia	5774	1367	23.68%	25%	2675
Delaware	5064	932	18.40%	15%	2339
Fulton	6674	861	12.90%	23%	3063
Genesee	4463	23	0.52%	21%	2051
Greene'	4566	1077	23.59%	20%	2120
Hamilton	315	0	0.00%	16%	142
Herkimer'	6339	934	14.73%	15%	2910
Livingston'	5276	202	3.83%	52%	2472
Madison'	5122	558	10.89%	12%	2348
Montgomery	5706	759	13.30%	29%	2609
Ontario	6800	714	10.50%	58%	3202
Orleans	4745	0	0.00%	16%	2203
Oswego'	14362	0	0.00%	14%	6704
Otsego	5036	969	19.24%	25%	2293
Putnam	2269	519	22.87%	19%	1033
Rensselaer	14707	4473	30.41%	57%	6861
St. Lawrence	15398	379	2.46%	3%	7143
Saratoga	9802	1298	13.24%	30%	4471
Schenectady	13362	3109	23.27%	46%	6221
Schoharie'	3107	310	9.98%	19%	1425
Seneca'	2587	197	7.61%	29%	1189
Sullivan	8935	796	8.91%	24%	4099
Ulster	15454	3587	23.21%	30%	7163
Warren	4992	1119	22.42%	29%	2270
Washington'	5704	1085	19.02%	29%	2648
Wayne'	6969	396	5.68%	57%	3252
Wyoming'	3067	0	0.00%	23%	1405
Yates	2419	159	6.57%	19%	1112
Total	235517	27768	11.79%		108974

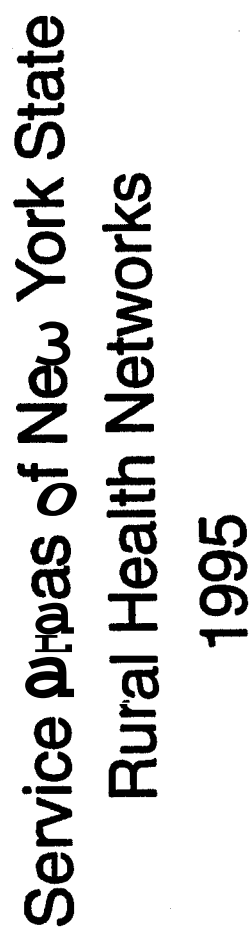
*Counties with less than 45 physicians per 100,000 population

Counties Where Partial Capitation or Fee For Service May Be Allowed

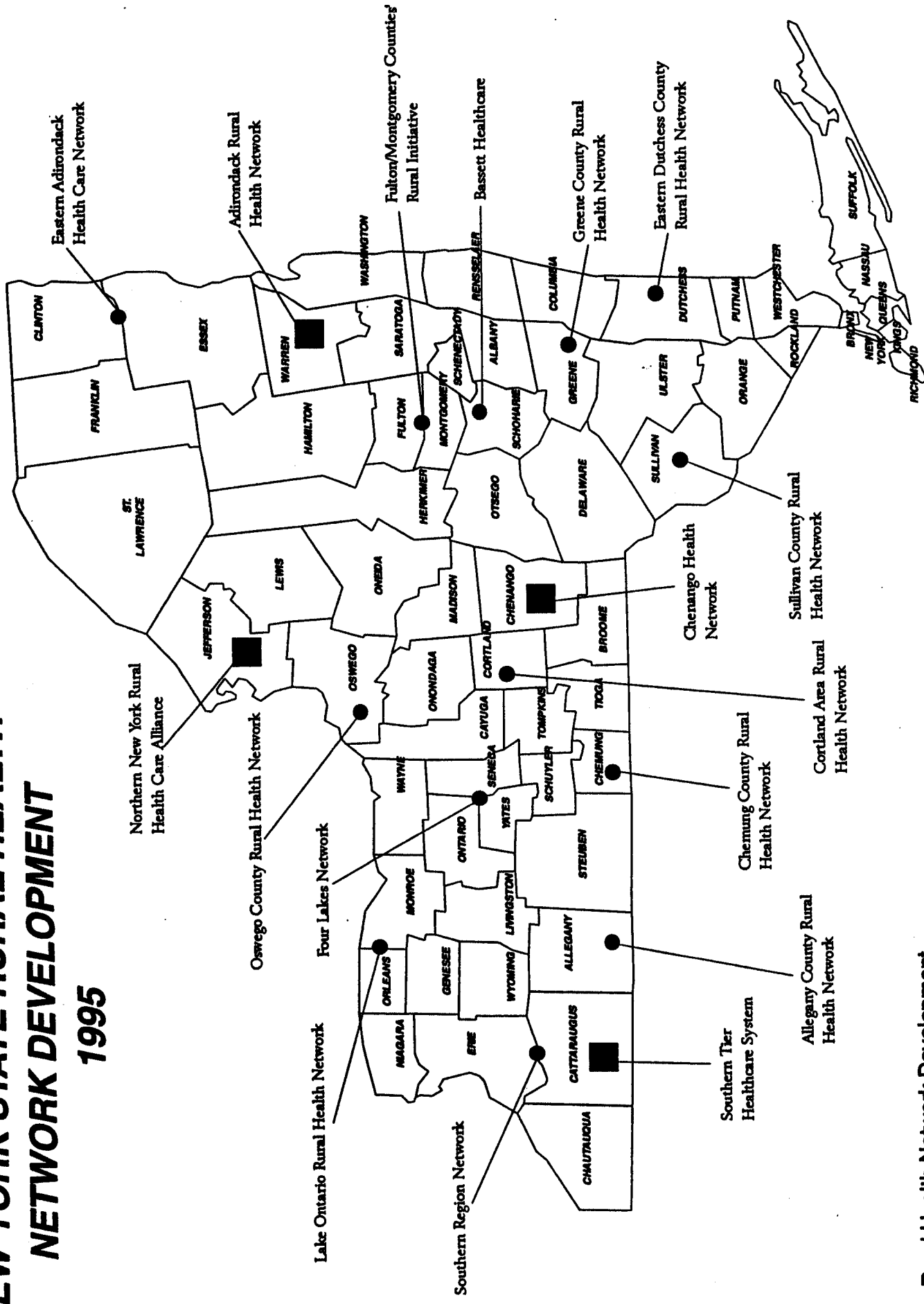
County	Medicaid Eligible'	Medicaid Enrolled In Managed Care*	Percent Enrolled in Medicaid Managed Care	Percent Total HMO Penetration **	Section 1115 Waiver Target—
Allegany	7637	728	9.53%	3%	3579
Cayuga	8010	0	0.00%	2%	3684
Chemung	11968	4548	38.00%	0%	5554
Cortland	5117	0	0.00%	3%	2367
Essex	4606	0	0.00%	8%	2137
Franklin	6297	457	7.26%	9%	2914
Jefferson	12890	0	0.00%	0%	5999
Lewis	2931	0	0.00%	0%	1341
Schuyler	2363	0	0.00%	0%	1098
Steuben	12145	0	0.00%	0%	5645
Tioga	4669	0	0.00%	4%	2177
Tompkins	6941	0	0.00%	2%	3211
Total	85574	5733	6.70%		39706
Grand Total	321091	33501	10.43%		148680

counties

1995



NEW YORK STATE RURAL HEALTH NETWORK DEVELOPMENT 1995



- Rural Health Network Development
- Central Services Facility Rural Health Network Development

AIDS AND HIV

Medicaid AIDS and HIV Provider Maps, By Region, New York State, 1995.

The following maps display the locations and range of providers certified by the New York State Department of Health's **AIDS** Institute (*AI*) to provide care to persons with HIV/AIDS. Certified providers are those meeting the performance standards and using the clinical guidelines developed by the AI. COBRA providers offer community-based case management services.

New York City Health and Hospital Corporation (HHC) hospitals have not yet been certified by the AI. However, they are included on ~~the~~ maps **because** they provide a substantial amount of care to those with HIV/AIDS.

Estimates of Number of Persons with AIDS

The number of **AIDS** cases shown for each county is the cumulative total reported over time to the **AIDS** Registry. The registry excludes those who are HIV positive but who do not yet have an AIDS diagnosis. Registry cases are periodically matched to death certificates in order to differentiate those who are still alive ~~from~~ those who have died. Those who have died are then removed from the registry. However, the numbers on the maps include persons who have died.

Additionally, the numbers shown on the maps ~~are~~ under-estimated because zip codes with low numbers of cases have ~~been~~ censored. Total cumulative cases shown statewide is **78,500**. About **2,900** cases are excluded from censored zip codes, for a cumulative total of **81,400** cases reported to the **AIDS** Registry ~~as~~ of September **30,1994**.

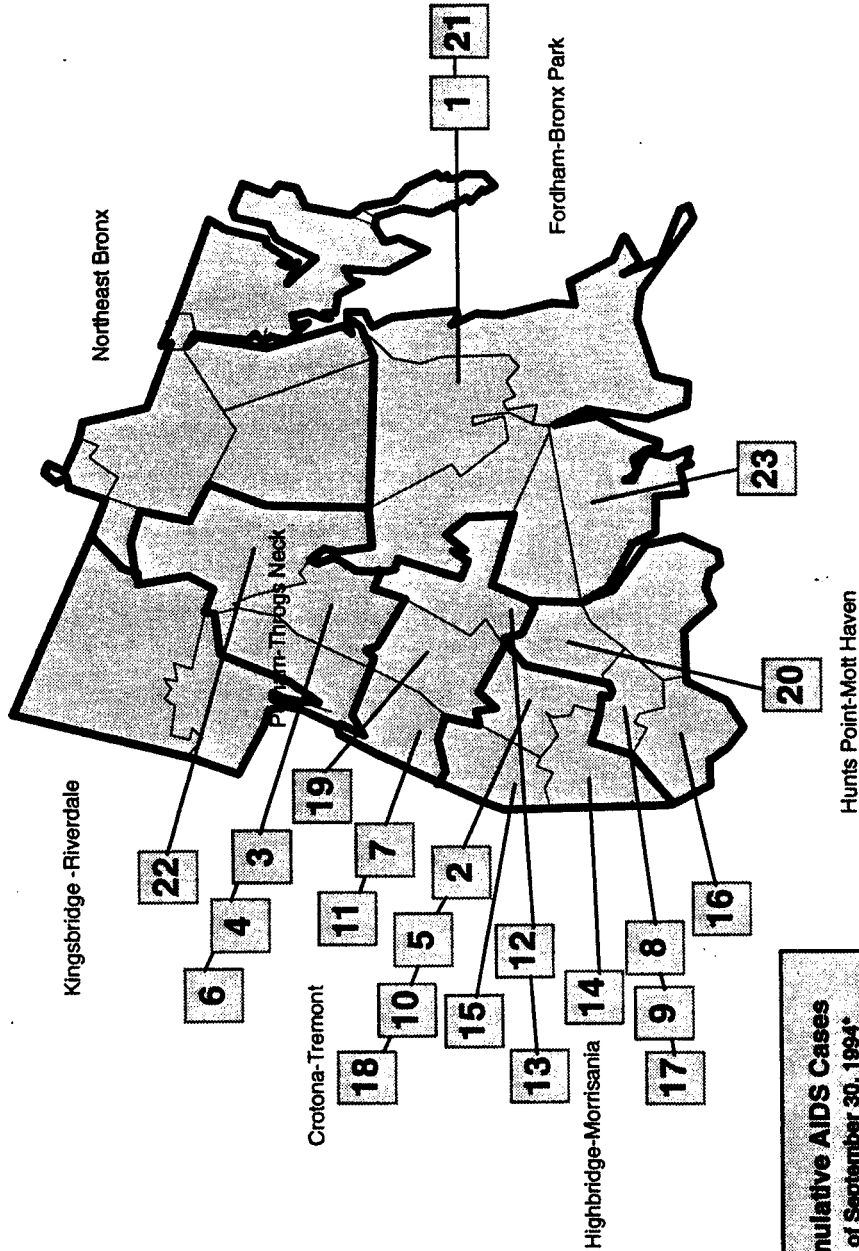
Bronx

AIDS Institute Medicaid HIV Providers

Providers -- Services

1. Albert Einstein College of Medicine - B,C,D
2. Argus Community, Inc. - B
3. Bronx AIDS Services, Inc. - B
4. Bronx Center for Families/Salvation Army - B
5. Citizens Advice Bureau - B
6. Help/Project Samaritan - B
7. Morris Heights Health Center - B, D
8. NARCO Freedom/Hope CM Services - B, D
9. United Bronx Parents Inc. - B
10. Bronx-Lebanon Hospital Center - C,D,E
11. Montefiore Medical Center - C,D,E
12. Promesa, Inc.- C,D
13. Tremont Commonwealth Council - C,D
14. Lincoln Medical/Mental Health Center - D,F
15. Morrisania Neighborhood FC Center - D
16. Segundo Ruiz Belvis Drug & Treatment - D
17. Hunts Point Multi-Services Center - D
18. Martin Luther King Jr. Med. Center - D
19. St. Barnabus Hospital - D
20. Urban Health Plan, Inc. - D
21. Bronx Municipal Hospital - D,F
22. North Central Bronx Hospital - D,F
23. Soundview Health Center - D

KEY	
A.	Home Care Provider
B.	COBRA Provider
C.	HIV Substance Abuse Medicaid Provider
D.	HIV Primary Care Medicaid Provider
E.	Designated AIDS Center Hospital
F.	HHC Hospital



Cumulative AIDS Cases As of September 30, 1994*	
Kingsbridge-Riverdale	302
Fordham-Bronx Park	2,117
Northeast Bronx	824
Pelham-Throgs Neck	1,946
Crotona-Tremont	2,530
Hunts Point-Mott Haven	1,793
Highbridge-Morrisania	2,839
Missing	461
Bronx Total	12,812

HIV-Enhanced Fee for Physicians # of Physicians Participating	
Bronx Total	40

• Source: AIDS Epidemiology Program, NYSDOH
Prepared by:
Information Systems Office
AIDS Institute, NYSDOH
February 1995

Manhattan

AIDS Institute Medicaid HIV Providers

Providers -- Services

1. Special Needs CHHA for Persons with AIDS - A

2. AIDS Service Center of Lower Manhattan - B

3. Dennelisse Corporation - B

4. Community Family Planning Council - B, D

5. Gaymen's Health Crisis - B

6. Greenwich House - B, C, D

7. Housing Works, Inc. - B

8. Upper Manhattan Task Force on AIDS - B

9. Village Center for Care - B

10. Women's Prison Association - B

11. Beth Israel Medical Center - C, D, E

12. Daytop Village - C, D

13. Lower Eastside Service Center - C, D

14. Reality House - C, D

15. St. Luke's/Roosevelt Hospital - C, D, E

16. Betance's Health Unit - D

17. Gouverneur D+TC - D

18. Cabrini Medical Center - D, E

19. Institute/Urban Family Health - D

20. Bellevue Hospital Center - D, F

21. NENA Comprehensive - D

22. St. Vincent's Hospital - D, E

23. Odyssey House - D

24. St. Clare's Hosp. & Med. Cent - D, E

25. NY Hospital - D, E

26. Lenox Hill Hospital - D, E

27. Covenant House - D

28. Phoenix House - D

29. William F. Ryan CHC - D

30. Sydenham Neighborhood - D

31. Metropolitan Hospital - D, F

33. Mount Sinai Hospital - D, E

34. Council's Ambulatory - D

35. Washington Heights - D

36. Presbyterian Hospital - D, E

37. East Harlem Council - D

38. North General Hospital - D, E
39. Harlem Hospital Center - D, F

40. NY Downtown Hospital - D

41. Coler Memorial Hospital - F

42. Goldwater Memorial Hospital - F

KEY

A. Home Care Provider

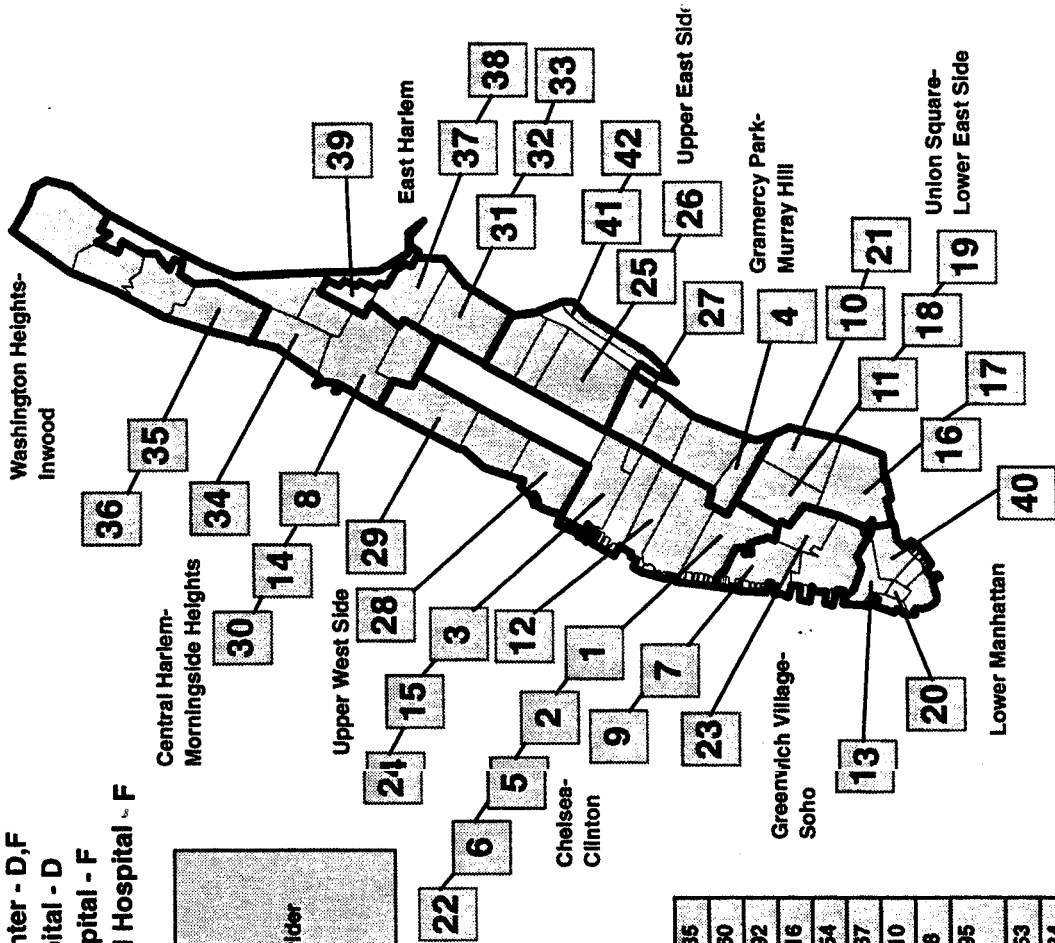
B. COBRA Provider

C. HIV Substance Abuse Medicaid Provider

D. HIV Primary Care Medicaid Provider

E. Designated AIDS Center Hospital

F. HHC Hospital



Cumulative AIDS Cases As of September 30, 1994*	
Washington Heights - Inwood	1,435
Upper West Side	4,060
Upper East Side	1,292
Chelsea - Clinton	4,416
Gramercy Park - Murray Hill	2,154
Greenwich Village-Soho	2,367
Union Square - Lower East Side	3,410
Lower Manhattan	278
Central Harlem - Morningside Heights	3,395
East Harlem	2,653
Missing	1,834
Manhattan Total	27,294

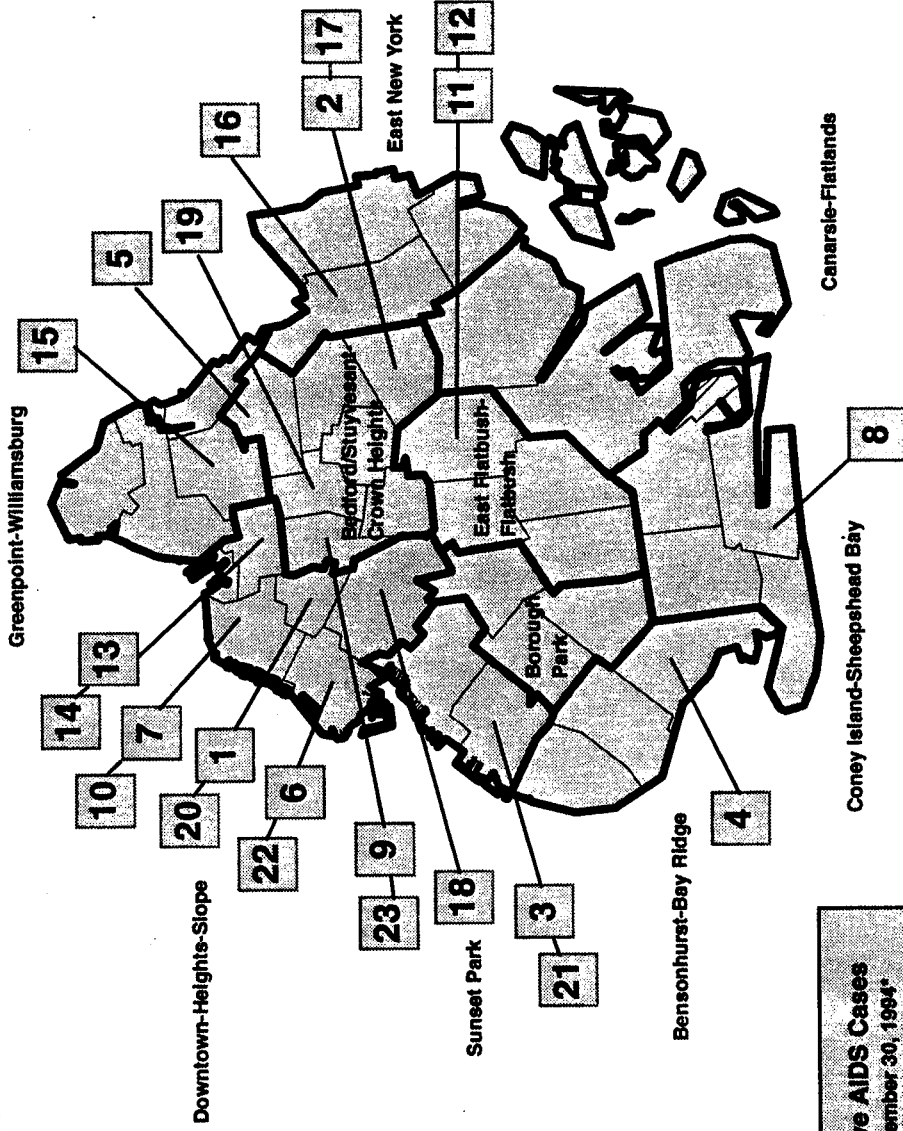
HIV-Enhanced Fee for Physicians # of Physicians Participating	
Manhattan Total	159

Brooklyn

AIDS Institute Medicaid HIV Providers

Providers -- Services

1. Brooklyn AIDS Task Force - B
2. Brownsville Multi-Service FHC - B,D
3. Discipleship Outreach Ministries - B
4. Heartshare Human Services of NY - B
5. Miracle Makers - B
6. Patrick Daley Health Center - B
7. Addiction Research & Treatment Corp - C,D
8. Coney Island Hospital - C,D,F
9. Interfaith Medical Center - C,D,E
10. Long Island College - D
11. Kings County Hospital - D,F
12. University Hospital (Brooklyn) - D,E
13. Cumberland Neighborhood Family Care Center - D
14. Lyndon Baines Johnson - D
15. Woodhull Medical/Mental Hospital - D,E,F
16. East New York Diagnosis - D
17. Brookdale Hospital - D,E
18. Methodist Hospital of Brooklyn - D
19. Bedford Stuyvesant Family Health Center - D
20. Brooklyn Plaza Medical Center - D
21. Lutheran Medical Center/Sunset Park - D,E
22. South Brooklyn Health Center - D
23. Wyckoff Heights Medical Center - D



Cumulative AIDS Cases As of September 30, 1994*	
Bedford/Stuyvesant-Crown Heights	4,250
East New York	1,482
Greenpoint-Williamsburg	2,252
Downtown-Heights-Slope	2,585
Sunset Park	588
East Flatbush-Flatbush	1,900
Coney Island-Sheepshead Bay	865
Bensonhurst-Bayridge	485
Borough Park	597
Canarsie-Flatlands	404
Missing	1,518
Brooklyn Total	16,966

KEY
A. Home Care Provider
B. COBRA Provider
C. HIV Substance Abuse Medicaid Provider
D. HIV Primary Care Medicaid Provider
E. Designated AIDS Center Hospital
F. HHC Hospital

HIV-Enhanced Fee for Physicians # of Physicians Participating	
Brooklyn Total	78

Queens

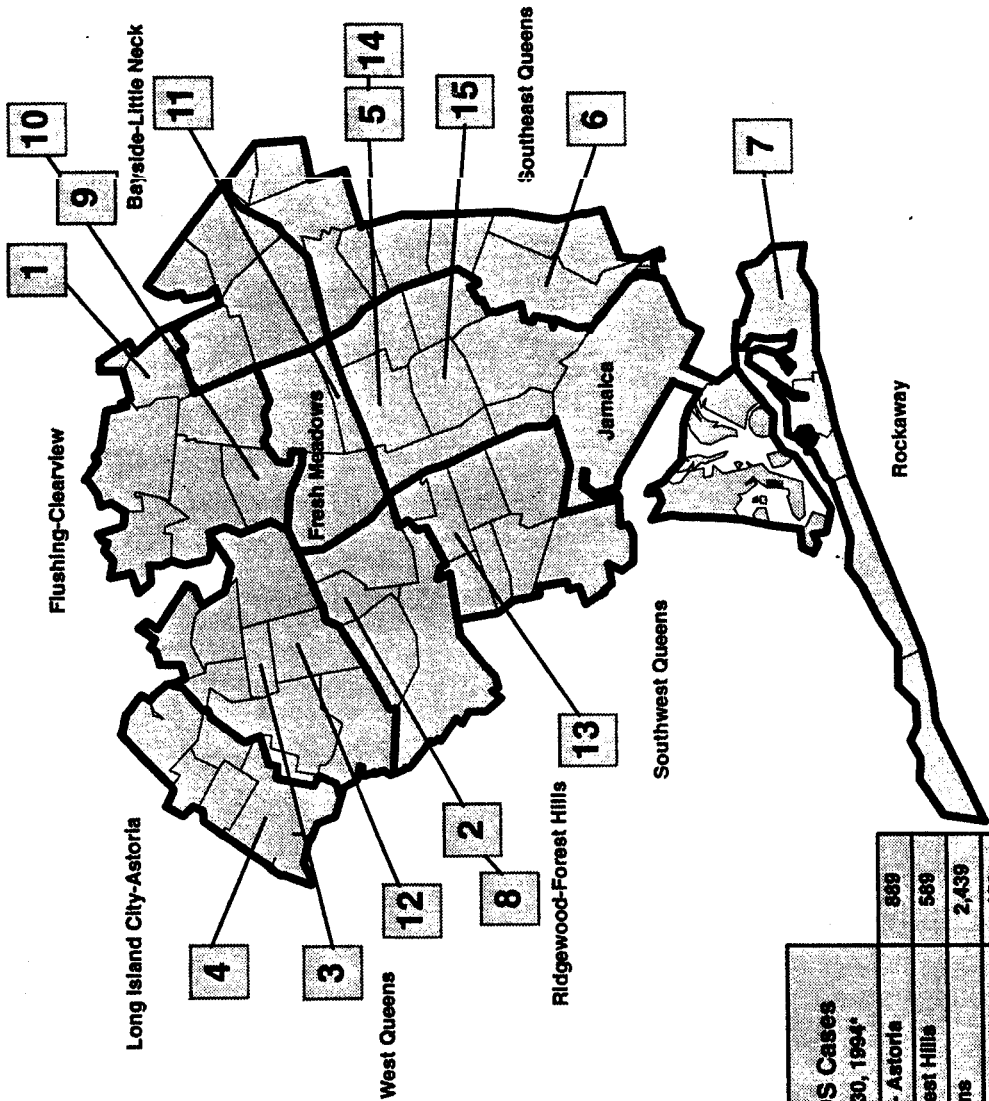
AIDS Institute Medicaid HIV Providers

Providers -- Services

- 1. St. Mary's Hospital for Children - A
- 2. AIDS Center of Queens County - B
- 3. Hispanic AIDS Forum - B
- 4. Bridge Plaza Treatment & Rehabilitation Services - C
- 5. Catholic Medical Center of Brooklyn & Queens - C,D
- 6. Jamaica Community Adolescent Program - C
- 7. St. John's Episcopal Hospital - C
- 8. Samaritan Village Inc. - C,D
- 9. Flushing Hospital Medical Center - D
- 10. NY Hospital Medical Center of Queens - D, E
- 11. Aurora Concept Incorp. - D
- 12. Elmhurst Hospital Center - D,F
- 13. Jamaica Hospital Medical Center - D
- 14. Queens Hospital Center - D,F
- 15. J-CAP Queens Village - D

KEY	
A.	Home Care Provider
B.	COBRA Provider
C.	HIV Substance Abuse Medicaid Provider
D.	HIV Primary Care Medicaid Provider
E.	Designated AIDS Center Hospital
F.	HHC Hospital

HIV-Enhanced Fee for Physicians # of Physicians Participating	
Queens Total	22



Cumulative AIDS Cases As of September 30, 1994*	
Long Island City - Astoria	889
Ridgewood - Forest Hills	589
West Queens	2,439
Fresh Meadows	159
Flushing Clearview	419
Bayshore Little Neck	125
Southeast Queens	575
Jamaica	1,803
Southwest Queens	865
Rockaway	476
Missing	537
Queens Total	8,927

* Source: AIDS Epidemiology 7 00m, NYSDOH
Prepared by:
Information Systems Office
AIDS Institute, NYSDOH
February 1995

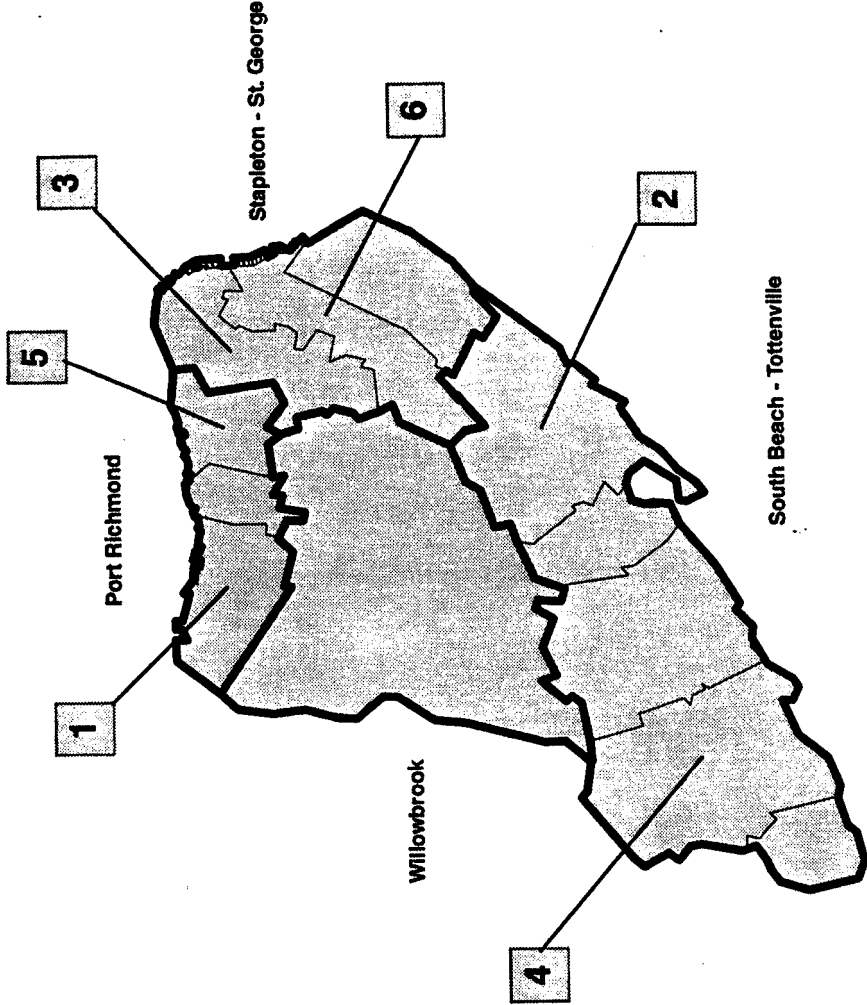
Staten Island

AIDS Institute Medicaid HIV Providers

Providers -- Services

1. VNA Homecare of Staten Island, Inc. - A
2. Richmond Home Need Services - B
3. Staten Island AIDS Task Force - B
4. Staten Island University Hospital - C, D
5. St. Vincent's Medical Center of Richmond - D, E
6. Bayley Seton Hospital - D, E (Pending)

KEY
A. Home Care Provider
B. COBRA Provider
C. HIV Substance Abuse Medicaid Provider
D. HIV Primary Care Medicaid Provider
E. Designated AIDS Center Hospital



Cumulative AIDS Cases As of September 30, 1994*	
Port Richmond	266
South Beach-Tottenville	335
Stapleton-St. George	602
Willowbrook	142
Missing	42
Staten Island Total	1,387

HIV-Enhanced Fee for Physicians # of Physicians Participating	
Staten Island Total	4

• Source: AIDS Epidemiology Program, NYSDOH
Prepared by:
Information Systems Office
AIDS Institute, NYSDOH
February 1995

Western New York Region

AIDS Institute Medicaid HIV Providers

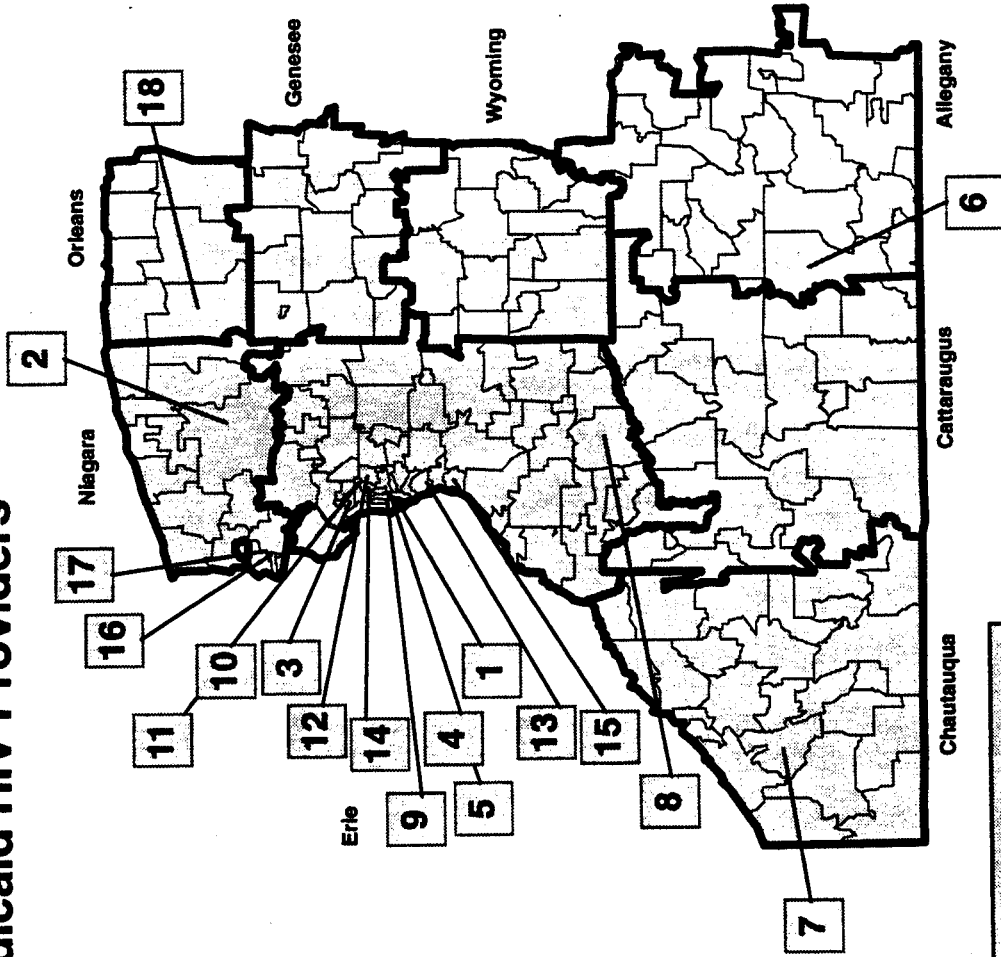
Providers -- Services

- 1. 24 Rhode Island - A
- 2. Niagara Department of Health - A, B
- 3. Schofield Residence - A
- 4. AIDS Community Services of Western New York - B
- 5. Buffalo Columbus Hospital - C, D
- 6. Cuba Memorial Hospital - D
- 7. Chautauqua County Health Department - D
- 8. Bertrand Chaffee Hospital - D
- 9. Sheehan Memorial Hospital - D
- 10. Geneva B. Scruggs Health Center - D
- 11. Horizon Human Services - D
- 12. Erie County Medical Center - D, E
- 13. Mercy Hospital of Buffalo - D
- 14. Children's Hospital of Buffalo - D
- 15. Roswell Park Cancer Institute - D
- 16. Niagara Falls Memorial Medical Center - D
- 17. Planned Parenthood of Niagara County - D
- 18. Medina Memorial Hospital - D

KEY	
A.	Home Care Provider
B.	COBRA Provider
C.	HIV Substance Abuse Medicaid Provider
D.	HIV Primary Care Medicaid Provider
E.	Designated AIDS Center Hospital
F.	HHC Hospital

• Source: AIDS Epidemiology Program, NYSDOH

Prepared by:
Information Systems Office
AIDS Institute, NYSDOH
February 1995



Cumulative AIDS Cases As of September 30, 1994*	
Niagara	97
Orleans	11
Genesee	16
Erie	611
Chautauqua	35
Cattaraugus	22
Western NY Region Total	792

HIV-Enhanced Fee for Physicians # of Physicians Participating	
Niagara	2
Orleans	1
Erie	12
Chautauqua	8
Cattaraugus	1
Allegany	2
Western NY Region Total	26

Genesee and Wyoming have no participants.

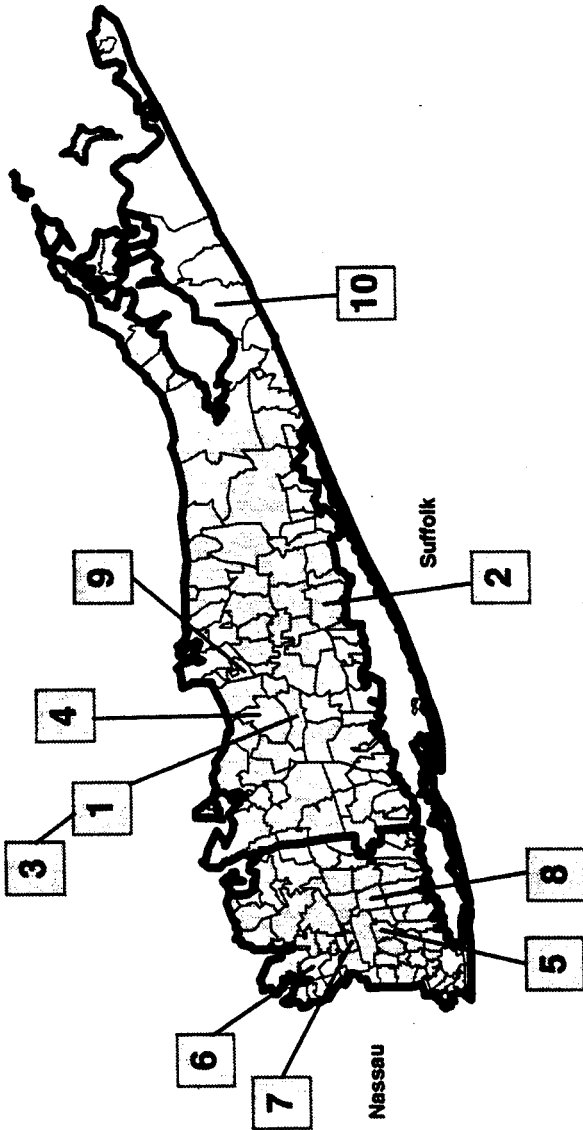
Allegany and Wyoming have no cases.

Long Island Region

AIDS Institute Medicaid HIV Providers

Providers -- Services

1. Suffolk County Department of Health - A, B, C, D
2. Brookhaven Memorial Hospital Medical Center - A, D
3. APPLE Drug Treatment, Inc. - B, C, D
4. Options for Community Living - B
5. Nassau County Department of Drug & Alcohol Abuse - C, D
6. North Shore University Hospital - D, E
7. Nassau County Department of Health - D
8. Nassau County Medical Center - D, E
9. University Hospital (Stony Brook) - D, E
10. Southampton Hospital - D



KEY	
A.	Home Care Provider
B.	COBRA Provider
C.	HIV Substance Abuse Medicaid Provider
D.	HIV Primary Care Medicaid Provider
E.	Designated AIDS Center Hospital

• Source: AIDS Epidemiology Program, NYSDOH
Prepared by:
Information Systems Office
AIDS Institute, NYSDOH
February 1995

Cumulative AIDS Cases As of September 30, 1994*	
Nassau	1,850
Suffolk	1,918
Long Island Region Total	3,768

HIV-Enhanced Fee for Physicians # of Physicians Participating	
Nassau	31
Suffolk	26
Long Island Region Total	57

Western New York Region

AIDS Institute Medicaid HIV Providers

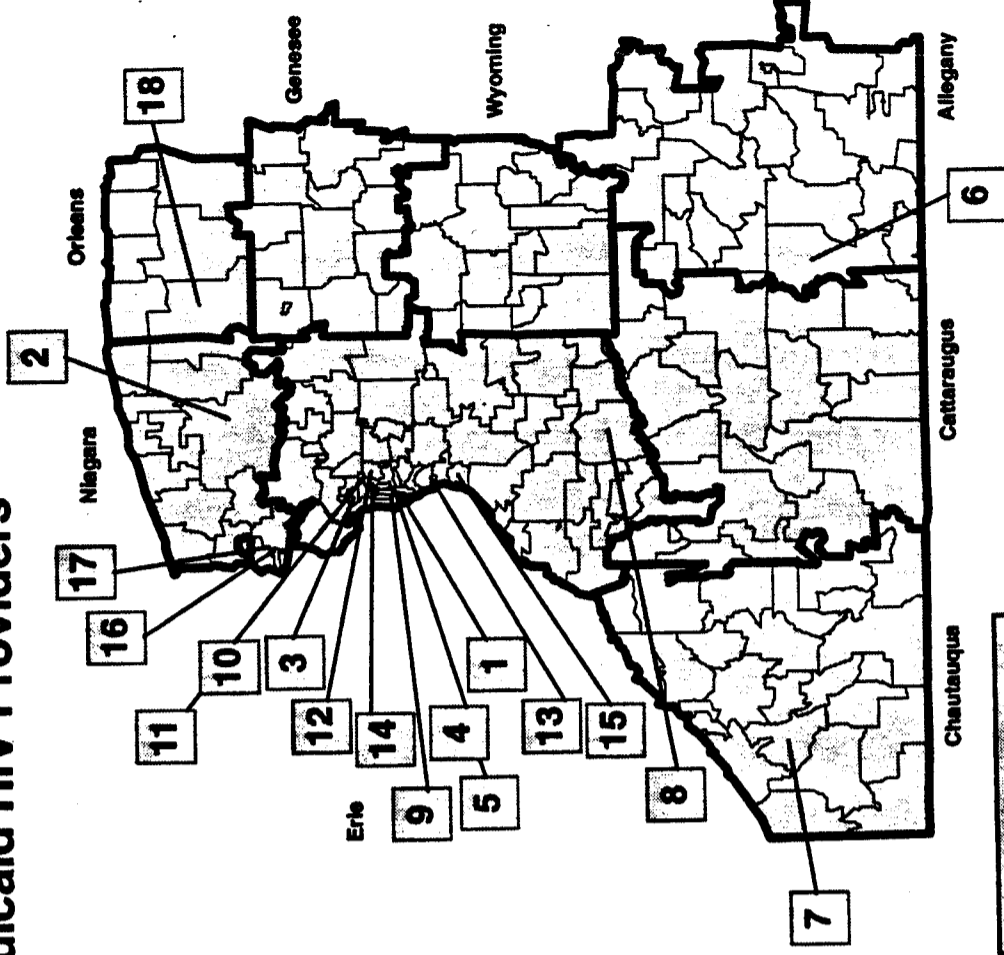
Providers -- Services

1. 24 Rhode Island - A
2. Niagara Department of Health - A, B
3. Schofield Residence - A
4. AIDS Community Services of Western New York - B
5. Buffalo Columbus Hospital - C, D
6. Cuba Memorial Hospital - D
7. Chautauqua County Health Department - D
8. Bertrand Chaffee Hospital - D
9. Sheehan Memorial Hospital - D
10. Geneva B. Scruggs Health Center - D
11. Horizon Human Services - D
12. Erie County Medical Center - D, E
13. Mercy Hospital of Buffalo - D
14. Children's Hospital of Buffalo - D
15. Roswell Park Cancer Institute - D
16. Niagara Falls Memorial Medical Center - D
17. Planned Parenthood of Niagara County - D
18. Medina Memorial Hospital - D

KEY	
A.	Home Care Provider
B.	COBRA Provider
C.	HIV Substance Abuse Medicaid Provider
D.	HIV Primary Care Medicaid Provider
E.	Designated AIDS Center Hospital
F.	MHC Hospital

• Source: AIDS Epidemiology Program, NYSDOH

Prepared by:
Information Systems Office
AIDS Institute, NYSDOH
February 1995



Cumulative AIDS Cases
As of September 30, 1994*

Niagara	97
Orleans	11
Genesee	16
Erie	611
Chautauqua	35
Cattaraugus	22
Western NY Region Total	792

*Allegany and Wyoming have no cases.

HIV-Enhanced Fee for Physicians
of Physicians Participating

Niagara	2
Orleans	1
Erie	12
Chautauqua	8
Cattaraugus	1
Allegany	2
Western NY Region Total	26

Genesee and Wyoming have no participants.

Long Island Region

AIDS Institute Medicaid HIV Providers

Providers -- Services

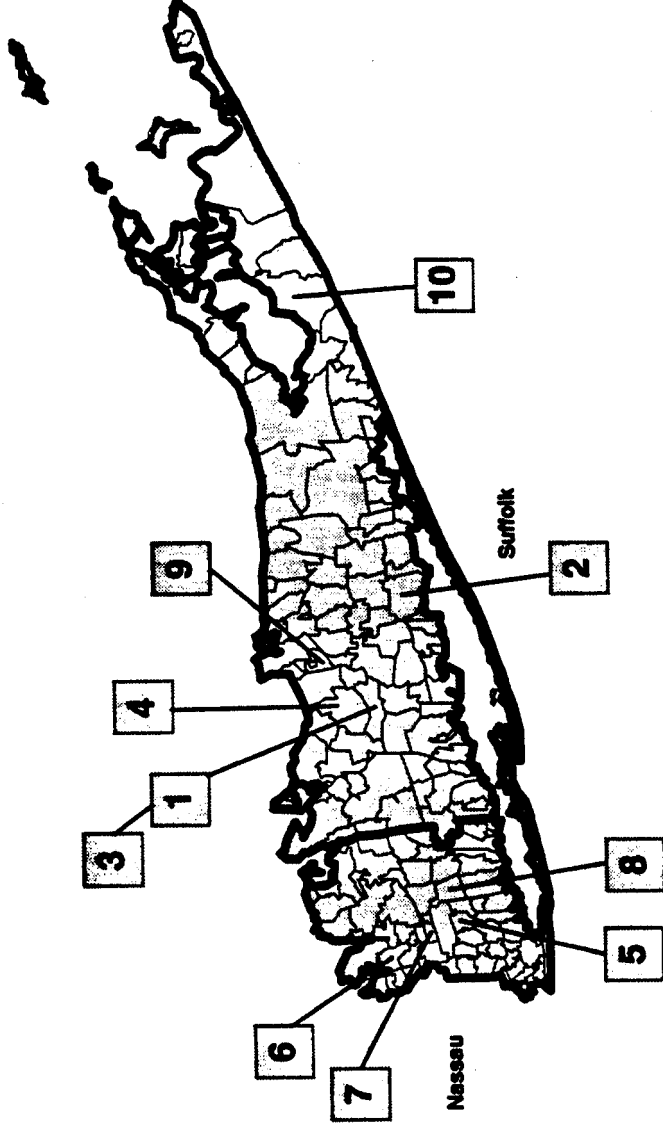
1. Suffolk County Department of Health - A, B, C, D
2. Brookhaven Memorial Hospital Medical Center - A, D
3. APPLE Drug Treatment, Inc. - B, C, D
4. Options for Community Living - B
5. Nassau County Department of Drug & Alcohol Abuse - C, D
6. North Shore University Hospital - D, E
7. Nassau County Department of Health - D
8. Nassau County Medical Center - D, E
9. University Hospital (Stony Brook) - D, E
10. Southampton Hospital - D

KEY

- A. Home Care Provider
- B. COSRA Provider
- C. HIV Substance Abuse Medicaid Provider
- D. HIV Primary Care Medicaid Provider
- E. Designated AIDS Center Hospital

• Source: AIDS Epidemiology Program, NYSDOH

Prepared by:
Information Systems Office
AIDS Institute, NYSDOH
February 1985



Cumulative AIDS Cases As of September 30, 1984*		
Nassau	1,850	
Suffolk	1,918	
Long Island Region Total	3,768	

HIV-Enriched Fee for Physicians # of Physicians Participating		
Nassau	31	
Suffolk	28	
Long Island Region Total	57	

**ESTIMATED MENTAL HEALTH
UNMET BED NEED - MEDICAID INPATIENT**

TABLE 1

BY OFFICE OF MENTAL HEALTH REGION

REGION	INPATIENT ADULT	INPATIENT CHILDREN & YOUTH
Western	13	6
Central	33	20
Hudson River	26	0
New York City	279	53
Long Island	59	19
Statewide Total	410	97
% Unmet Need	11%	30%

Total Medicaid Need		
I/P Care	3896	328
Percent Medicaid		
Need Met	89%	70%

Acute Inpatient Adult - Approximately ninety percent of the Medicaid bed need has been met for the adult inpatient population. Of the estimated statewide Medicaid unmet need of 410 beds, **280 (65%)** of those beds **are** needed for the New York City area. The balance of the Medicaid unmet need is distributed throughout the four remaining regions. Expansion of Article **28** hospital psychiatric beds is anticipated to meet this statewide Medicaid unmet need.

Acute Children & Youth - Approximately **70%** of the Medicaid bed need has been met for the children and youth population. Of the estimated statewide Medicaid unmet need of **95** beds **55 (57%)** of those beds are needed for the New York City **area. The** balance of the unmet need is distributed throughout the four remaining regions. Expansion of Article **28** hospital psychiatric beds is anticipated to meet this statewide Medicaid unmet need.

**ESTIMATED MENTAL HEALTH
UNMET NEED (SLOTS!- MEDICAID OUTPATIENT**

Table 2

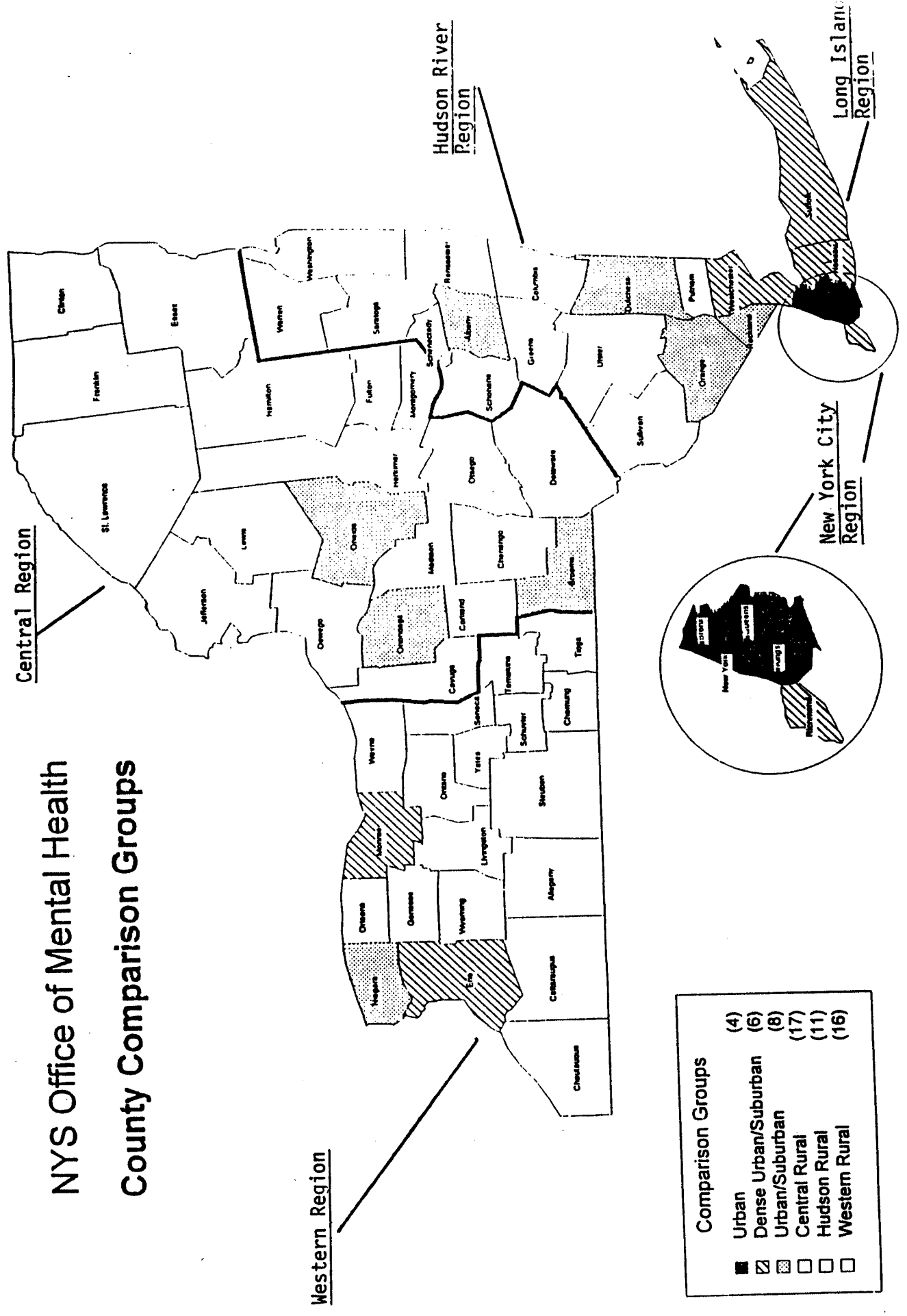
REGION	CON DAY TREATMENT	PSYCHIATRIC REHAB . TRAINING	PARTIAL HOSPITALIZATION
Western	185	39	106
Central	356	52	140
Hudson River	335	47	103
New York City	1061	236	485
	538	0	1
Statewide Total	2475	374	835
% Unmet Need	20%	25%	54%

Total Medicaid Need			
O/P care	12492	1515	1542
Percent Medicaid			
Need Met	80%	75%	46%

Continuing Day Treatment and Intensive Psychiatric Rehabilitation Training have **80%** and **75%** of their statewide Medicaid need met. The estimated Medicaid unmet need, **2,475** slots continuing day treatment and **375** slots intensive psychiatric rehabilitation training, is expected to be satisfied as pipeline and converting programs become liscensed under OMH Part **587** regulations.

Proportionally, Partial Hospitalization has the highest Medicaid unmet need of **55%** or **835** slots. A relatively new program which was started in **1991**, the program offers a alternative to acute care hospitalization. The program is currently under continued development in the needed regions.

NYS Office of Mental Health County Comparison Groups



VETERANS HEALTH CARE

MANAGING CARE FOR NY'S MEDICAID ELIGIBLE VETERANS

I. Veterans in New York

New York State is home to **1.69** million veterans, the fourth largest contingent in the nation. Including dependents, it is estimated that New York's veteran community numbers nearly **5** million. Although the veteran population is expected to decline over the decade, the number of veterans over **65** years of age will increase **as** will the percentage of minority and women veterans.

II. Resources for Veterans' Care: U.S. Department of Veterans Affairs (VA)

A. Facilities - There are 12 VA Medical Centers (VAMCs) serving New York's veterans, more facilities than any other state. They provide significant plant capacity, with facilities in rural and inner city locations and range from small community based clinics to large tertiary and specialty care medical centers with several hundred beds. The VA health care system averages **4,800** operating hospital beds, which include: **2,700** medical, **1,500** psychiatric and **600** surgical beds. The VA also operates a Vet Center Program at 12 community-based locations throughout the State.

B. Health Care Personnel - The VA employs an estimated **15,000** directly and another **37,000** indirectly, including **1,150** physician, **5,500** nursing and **85** dentist full-time employee equivalents.

III. VA Services

VA's scope of services ranges **from** primary to long term care. During **1993**, over **200,000** veterans were provided health care by the VA. Its specialty services include: AIDS/HTV, acute and long term psychiatric care, substance abuse treatment, hospital based home care, nursing and domiciliary care, hospice and respite services, cancer treatment, spinal cord injury services and prosthetic services. Many of VA's diagnostic and treatment services, such **as** radiation therapy and MRI's, are offered to community health care providers through sharing agreements. The Vet Centers provide readjustment counseling to veterans who are experiencing problems related to their having served in the military and to engage in community activities that will be of benefit to veterans.

IV. Medicaid Eligible Veterans

A. Preliminary Estimates - Data identifying the number of veterans on Medicaid in New York State do not exist. Therefore, preliminary estimates were developed using veteran income data by family size and comparing it to net income standards for Medicaid eligibility. It is estimated that at least 84,000 veterans, or 5% of the veteran population, living in New York State meet the income guidelines for Medicaid eligibility. It should be noted that other Medicaid eligibility standards may result in qualifying additional veterans for Medicaid. Therefore, it is assumed the numbers in this table are conservatively low.

Since the data to determine Medicaid eligibility was from veterans with reported incomes, those whose income is not reported would also add to the number of Medicaid eligible. For example, it is estimated that 30% of the homeless and 40% of homeless males are veterans. The VA estimates that there are 14,000 homeless veterans in New York City. Due to the nature of homelessness, it would be safe to assume that this group would largely be Medicaid eligible.

B. Continued Information Gathering - Work is continuing with the VA and other State agencies to get a better idea of the number of Medicaid eligible veterans.

V. High cost/high risk Medicaid eligible veterans are being seen at the VA

Some 58% of New York's veterans have private health insurance coverage, 38% are publicly insured with Medicaid/Medicare and 7% are uninsured. Approximately 14% of New York's veterans use the U.S. Department of Veterans Affairs (VA) health care system. Those who do are poorer, sicker and have special needs. They have high rates of mental health problems, alcoholism and substance abuse and their disabilities are more severe.

The VA does not collect data on the Medicaid status of all of the veterans it serves. However, data for those who self-reported being on Medicaid was compiled and with 10 of the 12 VAMCs reporting, 4,493 veterans served reported being on Medicaid. This number is also conservatively low because it is self-reported.

VI. VA is interested in Medicaid Managed Care.

To improve veteran access to VA care, the Department of Health (DOH) has begun talks with the VA in New York concerning its capacities for participating in managed care for those veterans eligible for Medicaid and the general Medicaid population.

The VA is interested in participating in the State's planning for managed care and developing shared services agreements with the State and community providers. The VA believes it can be competitive with the private sector from both quality and cost of care perspectives.

It has been suggested that this process begin with three VA medical centers in New York City and two or three Upstate.

VII. A four-level approach to VA's participation in Medicaid Managed Care.

Reimbursement would be arranged the following ways:

- For the level of veterans eligible for medicaid and currently using the VA: no Medicaid dollars.
- For Medicaid eligible veterans who are not being treated by the VA and fall in the VA's "high priority" treatment categories: a negotiated Medicaid payment arrangement with the VA be worked out at a rate lower than the full capitation rate to account for the VA's responsibilities.
- For Medicaid eligible veterans who are not being treated by the VA, and fall into VA "low-priority" care categories: a capitation payment arrangement with the VA for services.
- For the general, non-veteran Medicaid population: a full capitated payment be arranged with VA hospitals that are interested and have the sufficient capacity.

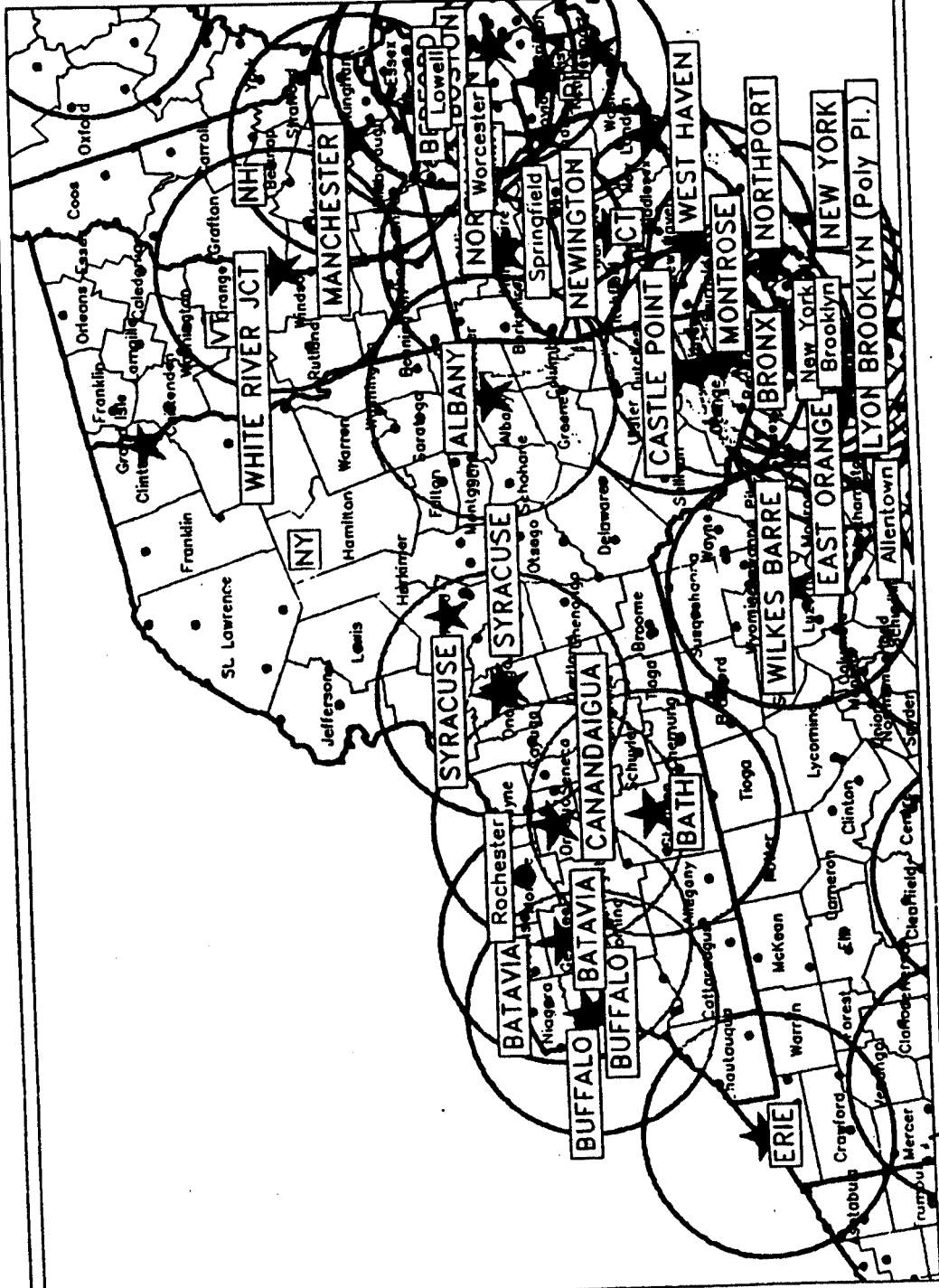
Under all of these arrangements, VA may develop agreements with other providers for services not available from the VA.

VIII. Limitations

- VA has finite resources available.
- VA has legal obligations for care, such as priority care for service-connected veterans.
- VA's participation can vary based upon individual medical center capacities.
- VA may not be authorized to serve the general Medicaid population (non-veterans).
- Individual VAMCs have not been authorized to re-invest revenue for capacity development.
- Veterans are often confused about who is actually eligible for VA care.
- Veterans cross-utilize systems (VA, Medicaid, Medicare, Dept. of Defense and private insurers) making it difficult for VA to manage care.

State of New York

Veteran Population (1990 Census) and Location of VA Medical Facilities



Legend

- 50_Mile_Radius
- County Boundaries
- NY Counties
- NY_Portion
- State Boundaries
- VA Community Based Clinic
- Community Hospital
- Independent Outpatient Clinic
- MilitaryHosp
- VA Satellite Outpatient Clinic
- VA Medical Center

New York Veteran Population
1990 Census
State Total: 1,690,365

White: 1,477,124
Black: 173,460
Nat.Amer.: 4,945
Hispanic: 75,235
Asian/Pacifics.: 9,129

DVA, National Center for Veterans
Analysis and Statistics 1/'93

Miles
0 50 100

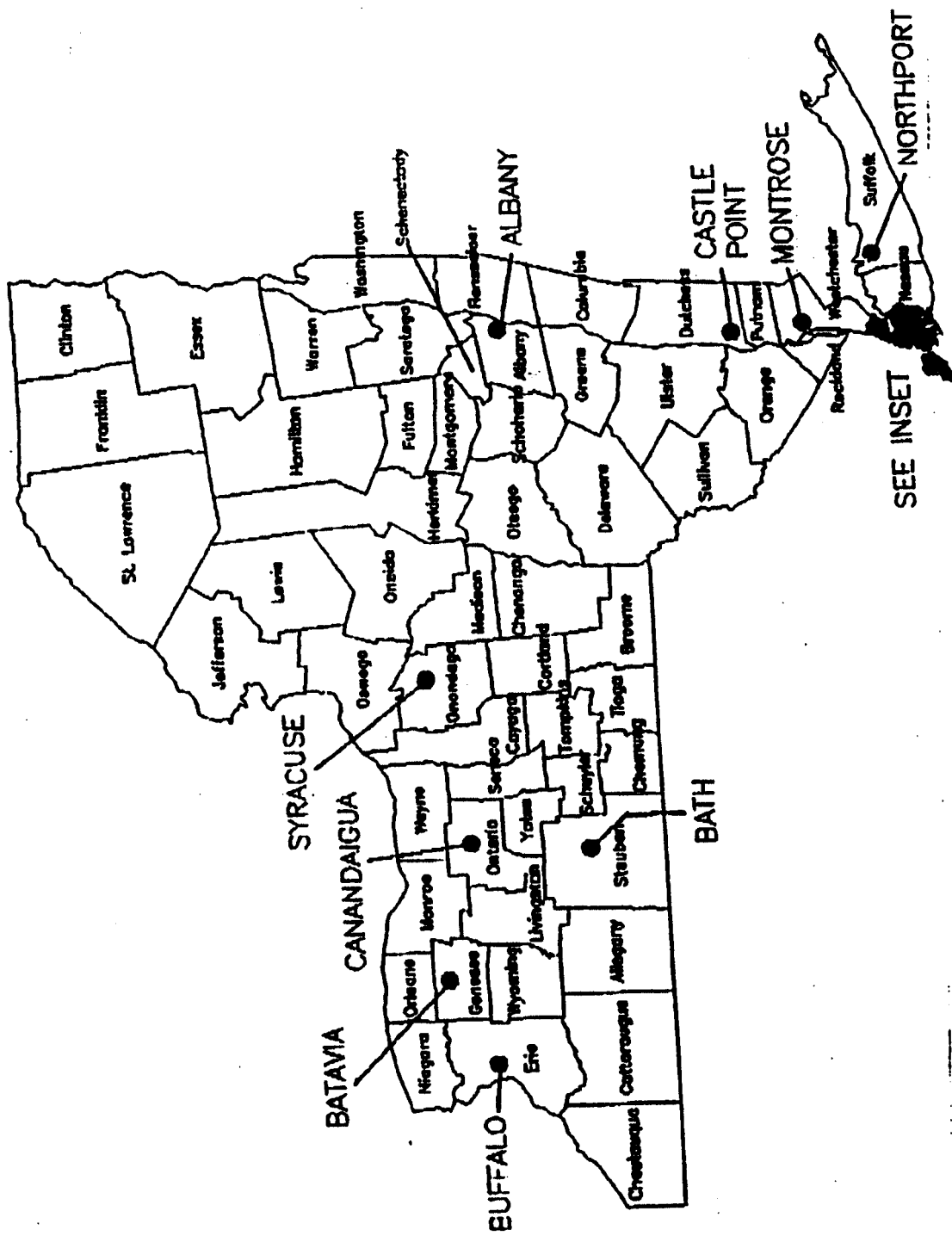
Estimated Veteran Population Within 50-Mile Radius of VA Medical Centers

Buffalo, Bath . . . Syracuse: 449,891

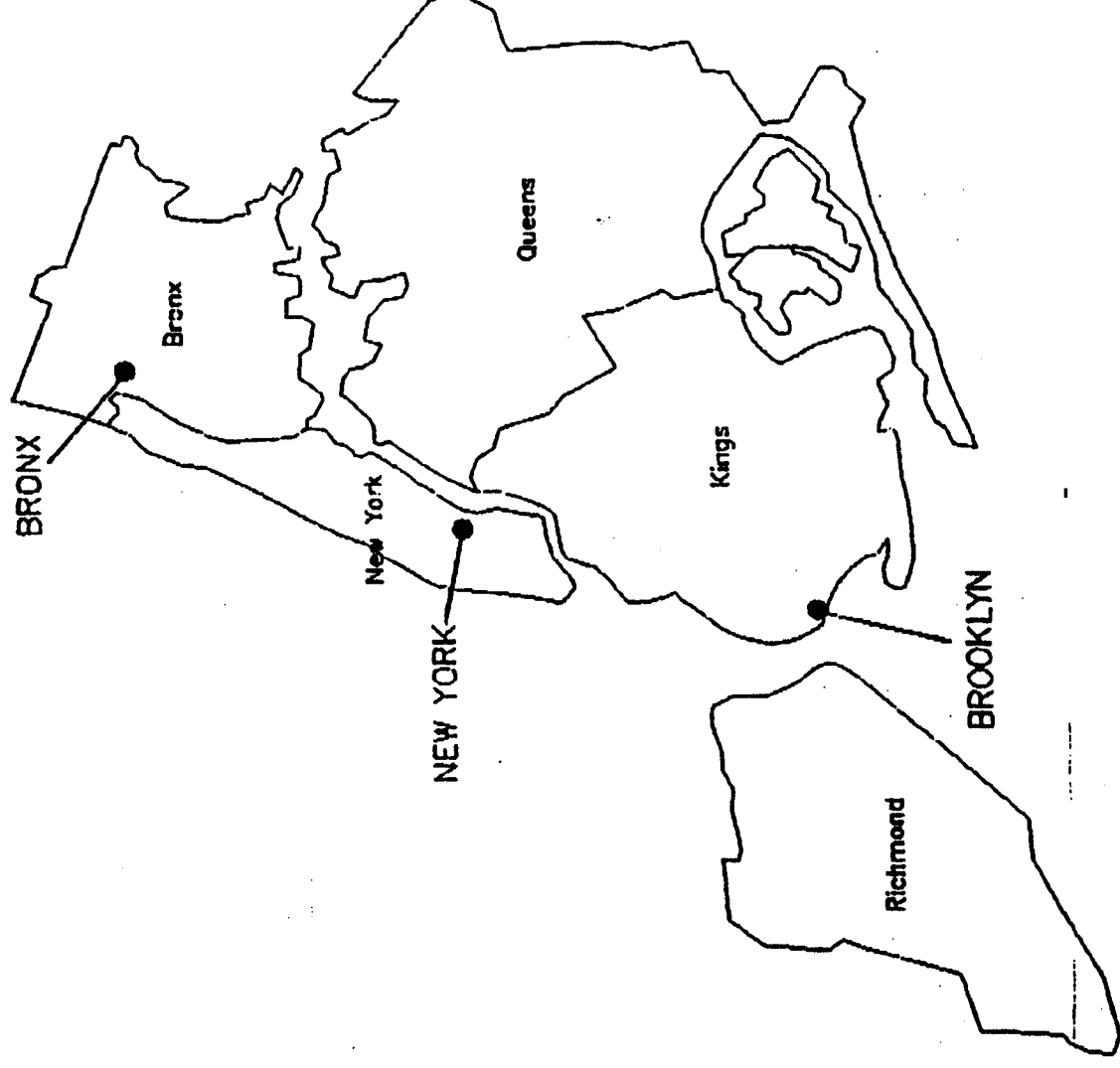
Albany . . . Brooklyn: 1,094,466

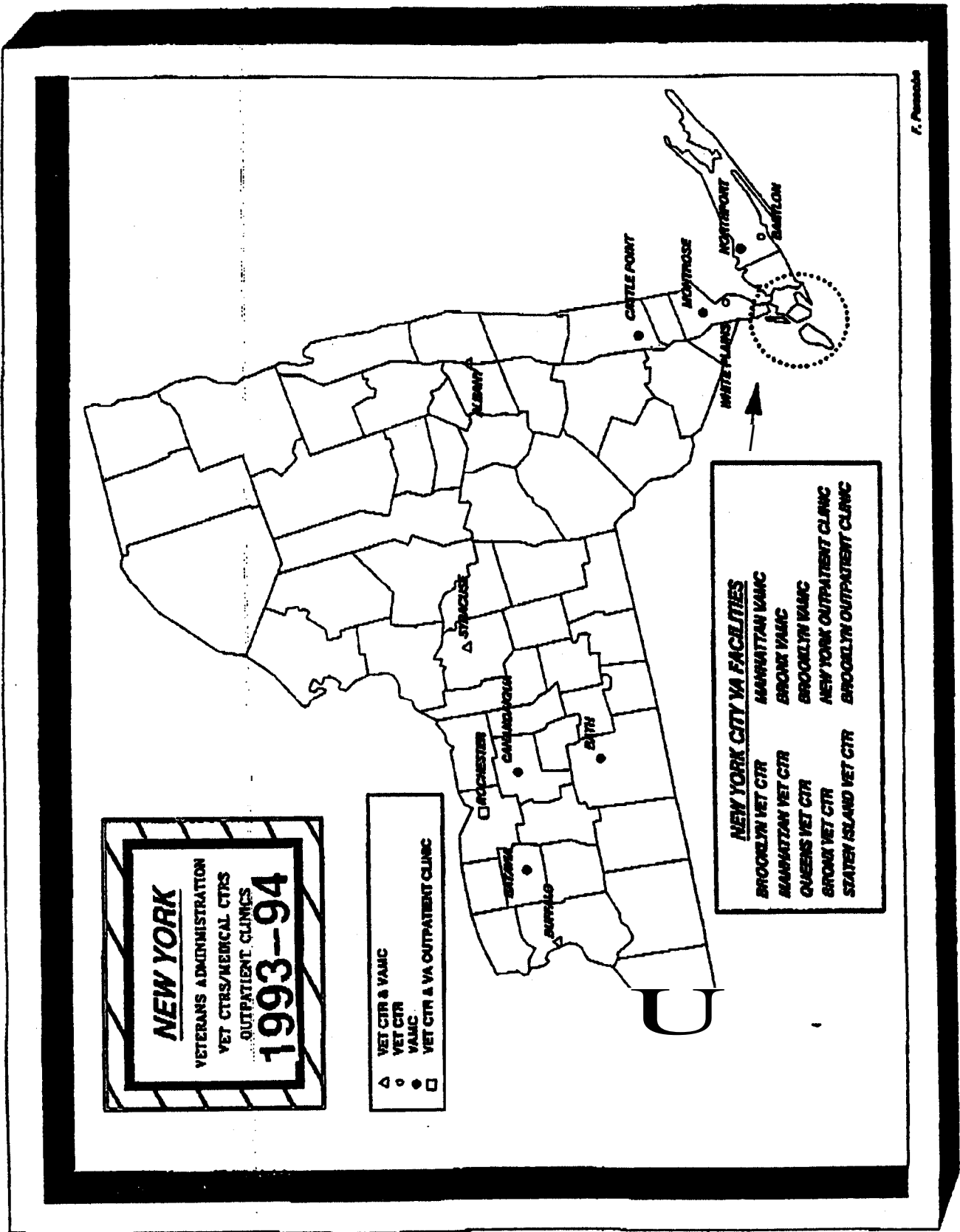
Total: 1,544,377

VA Veterans Health Administration Medical Centers



VA Veterans Health Administration Medical Centers





APPENDIX 2

**CRITERIA FOR DETERMINING SERIOUS AND PERSISTENT
MENTAL ILLNESS AND SERIOUS EMOTIONAL DISTURBANCE**

APPENDIX 2A

CRITERIA FOR SEVERE AND PERSISTENT
MENTAL ILLNESS AMONG ADULTS

To be considered an adult ~~diagnosed~~ with severe and persistent mental ~~illness~~ **A** must be met. In addition, B or C or D must be met:

A. Designated Mental Illness Diagnosis

The individual is **18** years of age or older and currently meets the criteria for a DSM-IV psychiatric diagnosis other than alcohol or drug disorders (**291.xx-292.xx, 303.xx-305.xx**); delirium, dementia, and amnesic and other cognitive disorders (**290.xx, 293.0x, 294.xx, 780.09, 780.9x**); developmental disabilities (**299.xx, 315.xx, 317.xx-319.xx**); or other conditions that ~~may~~ be a focus of clinical attention (**313.82, 316.xx, 332.xx333.xx, 995.q Vxx.xx**).¹ ICD-9-CM and ICD-10 categories and codes that do not have an equivalent in DSM-IV are also not included as designated mental ~~illness~~ diagnoses.

AND

B. SSI or SSDI Enrollment due to Mental Illness

The individual is currently enrolled in SSI or SSDI due to a ~~designated~~ mental illness.

OR

C. Extended Impairment in Functioning due to Mental Illness

The individual ~~must~~ meet 1 or 2 below:

1. The individual ~~has~~ experienced **two** of the following four functional limitations due to a designated mental ~~illness~~ Over the ~~past~~ 12 months on a **continuous** or intermittent basis:
 - a. **Marked** difficulties in **self-care** (~~personal~~ hygiene; diet; clothing avoiding injuries; securing health care or complying with medical advice).
 - b. **Marked** restriction of activities of **daily** living (~~maintaining~~ a residence; using transportation; day-to-day money management; ~~accessing~~ **community** services).
 - c. **Marked** difficulties in maintaining **social functioning** (establishing and maintaining social relationships; interpersonal interactions with primary ~~partner~~, children, other family members, friends, neighbors; social skills; ~~compliance~~ with ~~social~~ norms; appropriate ~~use~~ of leisure time).
 - d. Frequent deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner in work, home, or school settings (ability to complete tasks commonly found in work ~~settings~~ or in **structured** activities that ~~take~~ place in home or school settings; individuals may exhibit limitations in these **areas** when they repeatedly ~~are~~ unable to complete simple tasks within an established time period, make frequent errors or ~~tasks~~, or require assistance in the completion of ~~tasks~~).

¹ Inclusion of mental disorders due to a general medical condition (**293.8x-293.xx, 310.xx, 316.xx, 607.xx-625.xx, 78x.xx**) in the definition of designated mental illness is currently being reviewed by OMH.

2. The individual ~~has~~ met criteria for ~~ratings~~ of ~~50~~ or less on the ~~Global~~ Assessment of Functioning Scale (~~Axis~~ V of ~~DSM-IV~~ due to ~~a~~ designated mental illness over the ~~past~~ twelve months on a continuous or intermittent basis.

OR

D. Reliance on Psychiatric ~~Treatment~~, Rehabilitation, and Supports

A documented history shows that the individual, ~~at~~ some prior time, met the threshold for **C** (above), but symptoms and/or ~~functioning~~ problems ~~are~~ currently attenuated ~~by~~ medication or psychiatric rehabilitation and supports. Medication ~~refers~~ to psychotropic medications which may control certain primary manifestations of mental disorder, e.g., hallucinations, but may or ~~may~~ not affect **functional** limitations ~~imposed by~~ the mental disorder. Psychiatric rehabilitation ~~and supports~~ refer to highly structured and supportive ~~settings~~ which may greatly reduce the demands placed on the individual ~~and~~, thereby, minimize overt symptoms and signs of the underlying mental disorder.

APPENDIX 2B
CRITERIA FOR SERIOUS EMOTIONAL DISTURBANCE
AMONG CHILDREN AND ADOLESCENTS

To be considered a child or adolescent with serious emotional disturbance A must be met. In addition, B or C must be met:

A. Designated Emotional Disturbance **Diagnosis**

The youngster **is** younger than 18 years of age and currently meet the criteria for a DSM-IV psychiatric diagnosis other than alcohol or **drug** disorders (**291.xx-292.xx, 303.xx-305.xx**); delirium, dementia, and amnestic and other cognitive disorders (**290.xx, 293.xx, 294.xx, 780.9x**); developmental disabilities (**299.q 315.xx, 317.xx-319.xx**); or other conditions that *may* be a focus of clinical attention (**313.82, 316.q 332.xx-333.xx, 995.q Vxx.xx**).² ICD-9-CM and ICD-10 categories and **codes** that do not have **an** equivalent in **DSM-IV** are also not included as designated mental **illness** diagnoses.

AND

B. Extended Impairment in Functioning due to Emotional Disturbance

The youngster must meet 1 and 2 below:

1. The youngster **has** experienced functional limitations due to emotional disturbance Over the **past 12 months** on a continuous or intermittent basis. The functional problems must be at least moderate in at least two of the following or severe in at least one of the following areas.³
 - a. Self-care (**personal** hygiene; **obtaining** and eating food; **dressing** avoiding injuries).
 - b. Family life (capacity **to** live in a family or family-like **environment**; relationships with parents or substitute parents, siblings, and other relatives; behavior in family **setting**).
 - c. Social relationships (establishing and maintaining friendships; interpersonal interactions with **peers**, neighbors, and other **adults**; **social/ skills**; compliance with social norms; plan and appropriate use of leisure **time**).
 - d. Self-direction/self-control (ability to sustain focused attention for long enough periods of time to permit completion of **age-appropriate tasks**; **behavioral self-control**; appropriate judgment and value systems; decision-making ability).
 - e. Learning ability (school achievement and attendance; receptive **and** expressive language; relationships with teachers; behavior in school).
2. The youngster **has** met criteria for ratings of **50** or less on the Children's Global Assessment Scale (CGAS) due to emotional **disturbance** for the **past 12 months** on a continuous or intermittent **basis**.⁴

OR

² Inclusion of mental disorders due to a general medical condition (**293.8x-293.xx, 310.xx, 316.xx, 607.xx-625.xx, 78x.xx**) in the definition of designated mental illness **is** currently being reviewed by OMH.

³ It is intended that the clinician **asses** the youngster's functioning in at least ~~these~~ five domains in consideration of assigning a single numerical rating on the CGAS.

⁴ While the CGAS is recommended, ratings of **50** or less on the Global Assessment of Functioning Scale (**Axis V of DSM-V**) may **be substituted**. The CGAS is described in Shaffer, **D. et al. (1983)** "A Children's Global Assessment Scale (CGAS)." Archives of General Psychiatry **40:1228-1231**.

C. Current Impairment in Functioning with Severe Symptoms

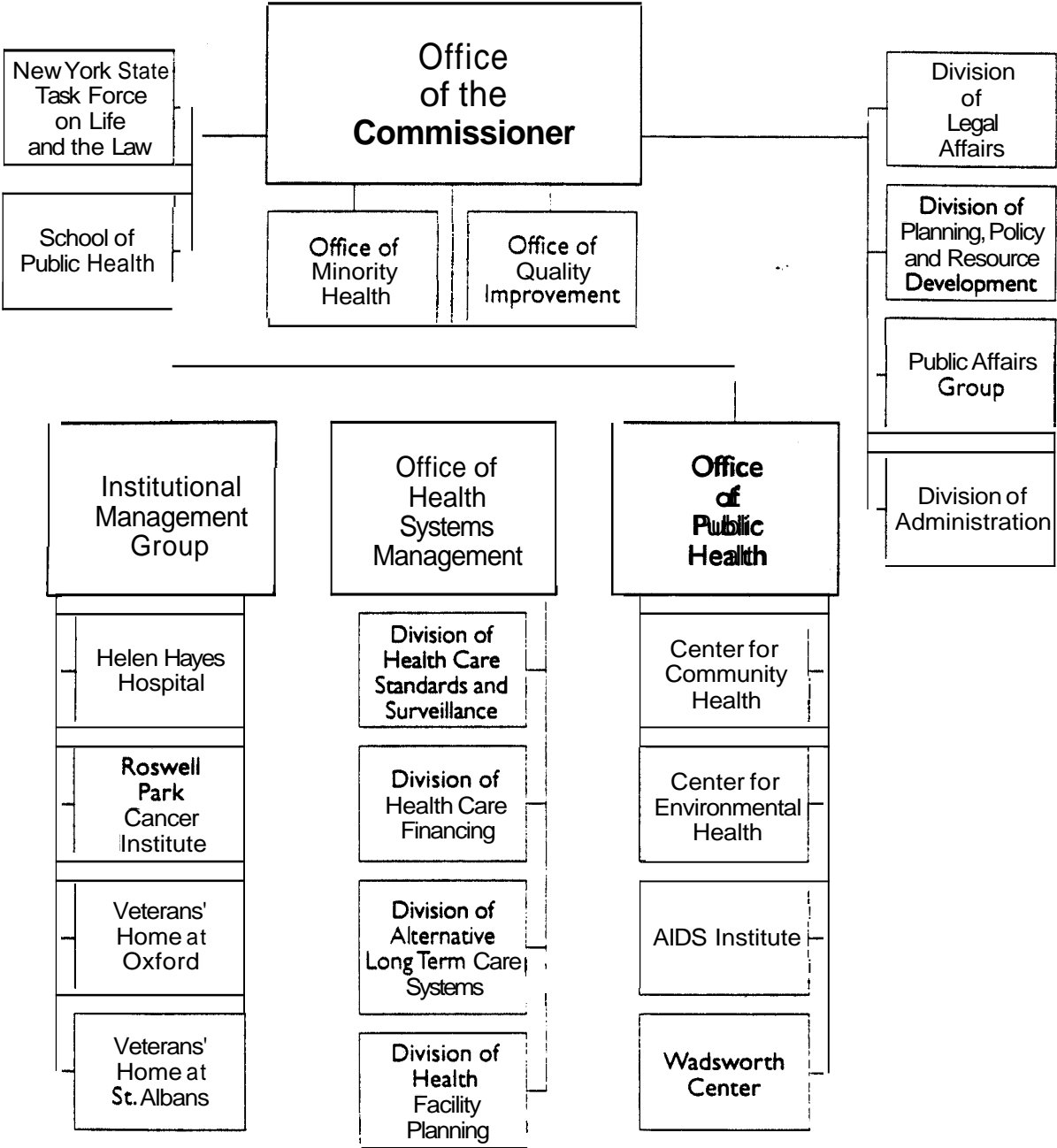
The youngster must meet **1 and 2** below:

- 1.** The youngster currently meets criteria for a rating of **50** or less on the Children's **Global Assessment Scale (CGAS)** due to emotional disturbance.³
- 2.** The youngster must have experienced at least one of **the** following within the **past 30 days**:
 - a.** Serious **suicidal** symptoms or other **We-threatening ,self-destructive behaviors**.
 - b.** Significant psychotic symptoms (hallucinations, delusions, **bizarre behavior**).
 - c.** Behavior **caused by** emotional **disturbances** that placed the youngster at risk of causing **personal injury** or significant property **damage**.

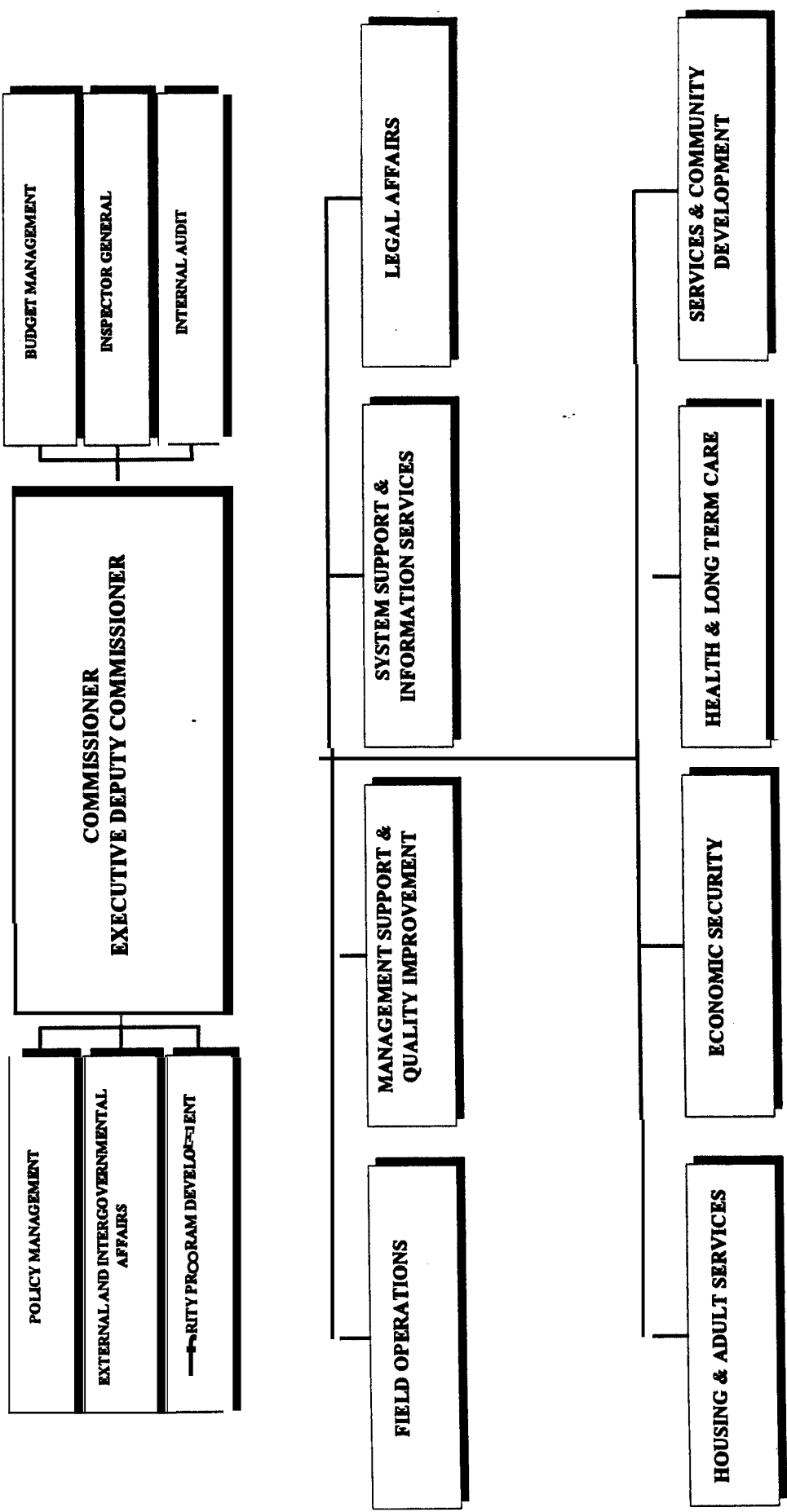
APPENDIX 3

**ORGANIZATIONAL CHARTS FOR
THE NEW YORK STATE DEPARTMENTS OF HEALTH AND SOCIAL SERVICES**

New York State Department of Health



NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES



APPENDIX 4

IMPLEMENTATION WORKPLAN AND TIMELINE

New York Medicaid Managed Care Initiative

Implementation Workplan Outline for The Partnership Program

The following pages contain a workplan outline describing the tasks the Department of Social Services, the Department of Health, and other State agencies will perform as part of the implementation of the New York Medicaid Managed Care Initiative. This program will operate under a Section 1115 Research and Demonstration Waiver and will serve the traditional Medicaid AFDC, SSI and MA only populations, as well as those persons made eligible for medical assistance under Title XIX through the conversion of the State's existing Home Relief Program.

This outline is intended to provide an overview of the steps necessary to implement the managed care program. As each task is begun, the work team assigned to that task may develop more detailed descriptions of the sub-tasks that must be performed.

The following tasks are to be completed prior to actual program start-up:

- Task 1: Disseminate a draft concept paper describing the Section 1115 waiver proposal, conduct public hearings, receive and incorporate input
- Task 2: Develop a structure and process for ongoing public communication and external relations
- Task 3: Develop and submit to HCFA a final 1115 demonstration waiver proposal
- Task 4: Contract for actuarial and other consulting and technical assistance necessary to implement the program (start-up phase)
- Task 5: Design and develop information systems modifications to support the new initiative
- Task 6: Evaluate agency organizational structures at DSS and DoH, identify options and assess the feasibility of reconfiguring the existing administrative structure to support the reform program
- Task 7: Collect and assemble a database for capitation rates and for distribution to potential managed care contractors
- Task 8: Develop participation requirements for fully capitated delivery systems
- Task 9: Prepare the prepaid health plan Request for Proposal (RFP) and provide technical assistance to potential contractors, evaluate proposals, select contractors and execute agreements
- Task 10: Identify special program initiatives to be incorporated into the Demonstration
- Task 11: Develop program participation standards for Special Needs Plans (SNPs)
- Task 12: Establish payment methodologies, risk sharing arrangements and rates for SNPs
- Task 13: Execute contracts with SNPs

The following tasks are to be completed prior to actual program start (continued):

- Task 14: Develop assignment algorithm for recipients who fail to select a plan (HMO, PHSP, SNP)
- Task 15: Develop alternatives to HMO/PHSP/SNP enrollment if total plan capacity is inadequate to serve potential enrollees
- Task 16: Develop and implement a provider beneficiary education program
- Task 17: Develop outreach and enrollment process and conduct initial phase enrollment
- Task 18: Prepare and promulgate rules and policy manual and modify State plan

Task 1: Disseminate a draft concept paper describing the Section 1115 waiver proposal, conduct public hearings, receive and incorporate input

Timeframe: February - March 1995

As a first task, the State will draft a concept paper describing the objectives and overall structure for New York's managed care initiative. The concept paper will be distributed to the public and modified based on comments received from program "stakeholders". The State then will use the revised concept paper as the basis for producing a draft of the formal waiver proposal to be submitted to HCFA. This draft also will be made available for review and comment by the public, and will be used to brief key legislators regarding the nature of the program.

Subtasks

- 1.1 Develop program concepts
- 1.2 Draft and disseminate a concept paper and conduct public hearings on the program
- 1.3 Review proposed design based on public input through open meetings
- 1.4 Draft a waiver application document for final review and commentary
- 1.5 Modify draft based on input from State agencies, provider organizations and advocates ("stakeholders")
- 1.6 Receive and incorporate input from consumers
- 1.7 Brief key legislators and New York congressional delegation
- 1.8 Develop final draft document for public distribution

Task 2: Develop a structure and process for ongoing public communication and external relations

Timeframe: April - June 1995

The communication efforts undertaken in Task 1 will be converted into an ongoing process, to ensure program stakeholders are regularly briefed and kept informed about all implementation activities.

Subtasks

- 2.1 Identify key staff to serve as “point persons”
- 2.2 Assemble a list of key stakeholders
- 2.3 Prepare briefing materials for providers, advocacy organizations, State legislators and congressional delegation
- 2.4 Arrange private and group meetings with key stakeholders as appropriate
- 2.5 Prepare biweekly updates for DSS/DoH Commissioners on status of communication activities

Task 3: Develop and submit to HCFA a final 1115 demonstration waiver proposal and negotiate terms and conditions for the program

Timeframe: February - July 1995

The research and demonstration proposal drafted in Task 1 will be finalized for submission to HCFA. The proposal will include a request for waivers from a number of Title XIX program requirements (e.g., waivers permitting mandatory enrollment and lock-in periods).

Subtasks

- 3.1 Brief HCFA on program concepts and timeline
- 3.2 Develop and submit final document to HCFA (see Workplan 3A, on file following page, for a detailed task list incorporating all aspects of waiver development)
- 3.3 Respond in writing to all questions/issues raised by the HCFA review teams
- 3.4 Designate and brief State negotiating team members
- 3.5 Meet with HCFA review team to address major issues
- 3.6 Negotiate program financing with Budget Neutrality Task Force
- 3.7 Receive and review final waiver terms and conditions
- 3.8 Issue acceptance letter

Task 4: Contract for acquisition and other consulting and technical assistance necessary to implement the program (start-up phase)

Timeframe: April - June 1995

The development of a Medicaid managed care program will require assistance from consultants and actuaries with relevant project experience. The Departments of Social Services and Health will be responsible for arranging for such assistance.

Subtasks

- 4.1 Identify specific program needs which require consulting or actuarial assistance
- 4.2 Identify potential contractors
- 4.3 Issue RFP and receive proposals from qualified bidder
- 4.4 Negotiate scope of work and fees and expense budgets
- 4.5 Award and execute a contract with a qualified firm(s)

Task 5: Design and develop information systems modifications to support the new alternative

Outline: Following the Implementation Process

The implementation of a Medicaid managed care program requires development of a specialized Medicaid management information system. Systems design work will begin with completion of a requirements analysis that identifies user needs with regard to system definition for encounter processing, roster maintenance and capitation payments.

After completion of the requirements analysis, systems alternatives will be analyzed by the State. These alternatives will identify scope changes and contract considerations for the MMIS fiscal agent. A systems modification plan and detailed specifications for hardware, software and processing then will be developed, and technical assistance will be provided to the fiscal agent. Finally, the State will test the system for user acceptance and will carry out systems conversion and implementation activities.

The State is also planning to develop additional data base maintenance and reporting capabilities to support the demonstration project. Currently, data is downloaded from the MMIS for various ongoing and special analysis and reporting projects. The Division of Managed Care will expand these activities to include the extraction of encounter and enrollment information. The State plans to develop a data base which will be used by the Bureau of Economic and Data Analysis to support the information and analysis needs of the program. In particular, this data will be used for future ratesetting, budgeting, program evaluation, performance monitoring, utilization review and quality assurance.

Subtasks

- 5.1 Complete requirements analysis. Note that current encounter data reporting elements and procedures are being reevaluated. The State plans to revise the current formats to include HEDIS 2.0 measures and additional outcome data for quality assurance monitoring.
- 5.2 Develop detail specifications for modifications to WMS, MMIS, and EMEVS including phase-in schedule.
- 5.3 Develop detail specifications for Managed Care Data Base and Reporting System including hardware and software requirements.

- 5.4 Submit APD for MMIS changes and new Managed Care Data Base and Reporting System.
- 5.5 Prepare change request for fiscal agent for MMIS changes
- 5.6 Prepare RFP for technical assistance in the development and implementation of the new Managed Care Data Base and Reporting System.
- 5.7 Conduct procurement for technical assistance contract; evaluate proposals; select contractor.
- 5.8 Prepare detail test plans for each enhancement which addresses internal testing as well as interface testing with the managed care plans, the local DSS offices, and other external entities.
- 5.9 Conduct testing; resolve discrepancies; and obtain user acceptance.
- 5.10 Update documentation and procedures as required.
- 5.11 Implement enhancements.

Task 6: Evaluate agency organizational structures at DSS and DoH, identify options and assess the feasibility of reconfiguring the existing administration structure to support the reform program

Timeframe: March - June 1995

During the first half of 1995, the State Departments of Health and Social Services will identify the organizational changes needed to support program operations, and will identify the resources available among existing staff, the resources that must be added in-house and the services which are to be contracted out to consulting and management firms. The State will also delineate the responsibilities of the various agencies involved in the program. A plan for recruiting new staff will be developed consistent with this needs assessment.

Subtasks

- 6.1 Define necessary skill sets and evaluate existing resources
- 6.2 Finalize the organizational structure of the Division of Managed Care within the Department of Health
- 6.3 Develop a management plan and recruitment schedule
- 6.4 Delineate agency responsibilities
- 6.5 Execute intergovernmental agreements specifying these agreements
- 6.6 Identify administrative and support services to be contracted to consultants and/or current firms
- 6.7 Issue RFPs and evaluate proposals from potential contractors
- 6.8 Negotiate contracts and obtain HCFA approval for contracts of more than \$100,000

Task 7: Collect and assemble a database of capitation rates setting purposes and DSH distribution to potential managed care contractors

Timeframe: May - June 1995

At the start of this task, State representatives will identify available Medicaid utilization and expenditure data for setting capitation levels and ranges. If data is not available in sufficient detail, a plan will be drafted for the State to use in collecting detailed data for a sample of Medicaid beneficiaries. Once the data has been obtained, a databook will be prepared and the overall fee-for-service equivalency levels will be calculated. This work will serve as the baseline information used by the State's actuaries in developing capitation bid ranges. In developing this information, the State and City must make numerous policy decisions related to the manner in which DSH payments will be made to providers.

Subtasks

- 7.1 Determine available data
- 7.2 Develop claims data extract specifications
- 7.3 Extract claims data for State fiscal years 1992, 1993, and 1994
- 7.4 Design a plan for collection of detailed data from a sample of Medicaid beneficiaries (if necessary)
- 7.5 Collect and incorporate all payment data not reflected in MMIS claims extract (e.g., DSH payments)
- 7.6 Assess options and develop payment policies related to DSH funds
- 7.7 Prepare and disseminate a databook containing cost and utilization data for current Medicaid beneficiaries and describe any payment flows to providers which will be outside of the capitated system

Task 7: Collect and assemble a database for capitation resetting purposes and for distribution to potential contractors (continued)

Timeframe: May - June 1995

Subtasks

- 7.8 Meet with key stakeholders as necessary to review the database and answer questions
- 7.9 Calculate rough FFS equivalency levels (Statewide and regional)
- 7.10 Turn over database and databook to actuaries for development of capitation bid ranges

Task 8: Develop participation requirements for fully capitated delivery systems

Timeframe: May 1995

In this task, requirements will be established for participation in the program by fully capitated delivery systems. This will include a review of existing State statutes/regulations to identify any that may require modification. It also will include determining provider panel sizes and composition, application/documentation requirements, reinsurance/deferred liability funding mechanisms, and the development of quality standards, marketing guidelines and solvency standards.

Subtasks

- 8.1 Review all current program participation standards
- 8.2 Assess current statutory/regulatory limitations and identify modifications required to enhance participation in competitive model
- 8.3 Identify any special issues and provisions related to the State's public hospitals (HHC and County and State facilities)
- 8.4 Determine panel size (minimum and maximum) for primary care providers
- 8.5 Determine specific panel composition and provider/member ratios
- 8.6 Analyze whether allowances in panel size should be made for selected upstate areas (more rural counties)
- 8.7 Develop application and documentation requirements
- 8.8 Specify encounter data reporting requirements
- 8.9 Document the minimum data set for capitated encounters under the demonstration

Task 8: The 60 participation requirements for fully capitalised delivery systems (continued)

Timeframe: May 1995

Subtasks

- | | |
|------|---|
| 8.10 | Determine funding mechanisms for reinsurance programs and deferred liability provisions |
| 8.11 | Document quality standards and specify oversight functions |
| 8.12 | Specify marketing guidelines |
| 8.13 | Provide specific documentation of fiscal solvency requirements |
| 8.14 | Establish process for periodic operational and financial reviews of health plans |

Task 9: Prepare the prepaid health plan RFP and provide technical assistance to potential contractors, adequate proposals, select contractors and execute agreements

Timeframe: May - September 1995

A Request for Proposal process will be developed for use in selecting fully capitated health plans. This will include identifying health plan data requirements (e.g., encounter reporting), program policies (e.g., quality assurance activities), financial risk and other requirements consistent with the performance standards identified in Task 8. Along with the RFP itself, evaluation criteria will be developed for use in reviewing and scoring health plan proposals. Prior to release of the RFP, organizations intending to bid will be required to submit letters of intent and cooperate with a pre-operational plan review process. Prior to contract award, plans may be required to complete a full-scale on-site readiness review conducted by a team comprised of State staff and consultants.

After the RFP has been issued, bidder conferences will be held and technical assistance provided as necessary. The State will establish a committee process and structure to evaluate the bids, make awards and issue contracts.

Subtasks

- 9.1 Document proposal requirements for health plans, consistent with performance standards identified in Task 8
- 9.2 Establish bidder evaluation criteria
- 9.3 Develop bidder submittal forms and format including a Letter of Intent to Bid which interested health plans can submit prior to the release of the RFP
- 9.4 Develop encounter reporting specifications, Health plan performance standards and documentation requirements
- 9.5 Receive letters of intent
- 9.6 Finalize and distribute and summary level utilization data

Task 9: Prepare the prepaid health plan RFP and provide technical assistance to potential contractors (continued)

Timeframe: May - September 1995

Subtasks

- 9.7 Hold bidder's conference, answer questions and provide technical assistance
- 9.8 Establish committee procedures and structure to evaluate bids
- 9.9 Develop an evaluation guide and train evaluators in its use
- 9.10 Score technical proposals
- 9.11 Evaluate cost proposals of bidders meeting minimum technical requirements
- 9.12 To the extent necessary, employ a Best and Final Offer (BFO) process for negotiating payment levels with health plans whose initial bids are outside the established rate ranges
- 9.13 Schedule on-site readiness review as necessary
- 9.14 Prepare draft contract with terms and conditions
- 9.15 Specify "special" contract terms and conditions as necessary (these may be negotiated separately for each plan)
- 9.16 Submit HMO contracts to XCO for review and approval
- 9.17 Receive any HCFA-required modifications and incorporate into final contract
- 9.18 Execute contracts

Task 10: Identify special program initiatives to be incorporated into the Demonstration

Timeframe: March - May 1995

In Task 10, separate managed care programs will be developed for the “special needs” populations (HIV+ and SPMI/SED beneficiaries)¹. The programs will be designed to accommodate the unique service delivery and case management needs of these populations and may include provisions for contracting with networks other than those serving the general Medicaid population.

Subtasks

- 10.1 Document acute and long-term care service delivery and case management needs of special needs populations (HIV+ and SPMI/SED beneficiaries) (separately for each group)
- 10.2 Develop appropriate benefit packages, based on results of 10.1
- 10.3 Outline options for enrolling and serving special needs populations in managed care settings, including through the establishment of separate public and private managed care networks (“Special Needs Plans”)
- 10.4 Select managed care model(s) to be implemented for each group
- 10.5 Identify counties or regions within the State in which various models will be implemented
- 10.6 Develop a process for contracting with Special Needs Plans, if such contracting is to occur outside of competitive procurement structure being established for the general Medicaid population. As a part of this subtask, determine whether a single contract will be awarded in each geographic area for each special population group, or if multiple contracts will be awarded.

¹ The special initiatives populations are likely to include SPMI adults, SED children and HIV+ beneficiaries

Task 11: Develop Program Participation Standard Or Special Needs Plans (SNPs)

Timeframe: To be determined

Based on the results of Task 10, the specific service delivery, case management and administrative requirements for Special Needs Plans will be outlined in detail. These participation standards will parallel the detailed requirements developed in Task 8 for the fully capitated delivery systems serving the general Medicaid population.

Subtasks

- 11.1 Assess current statutory/regulatory limitations and identify modifications required to permit contracting with managed care networks established specifically for "special needs" population groups
- 11.2 Determine provider composition and service delivery standards for Special Needs Plans
- 11.3 Determine case management and administrative standards
- 11.4 Determine licensure requirements, the agency responsible for licensure, and the agency responsible for program oversight.
- 11.5 Define and implement SNP licensure process, including application form, review criteria, etc.
- 11.6 Convene meetings with interested/potential providers to explain the licensure process and requirements
- 11.7 Modify, as necessary, other participation standards developed in Task 8 to address activities of Special Needs Plans

Task 12: Establish payment methodologies, risk sharing arrangements and ratios for SNPs

Timeframe: To be determined

Depending on their final structure, the State may develop payment arrangements for Special Needs Plans separate from those developed for other plans. Because of the more intense service needs of the populations these plans will serve, the State may find it necessary to develop alternative reinsurance (stop loss) and other risk sharing mechanisms in order to limit plan financial exposure.

Subtasks

- 12.1 Evaluate payment and risk sharing methodology for plans serving the general Medicaid population, to determine if alternative approach is required for Special Needs Plans
- 12.2 As necessary, develop alternative ratesetting and risk sharing mechanisms to ensure financial viability of Special Needs Plans

Task 13: Execute contracts with SNPs

Timeframe: To be determined

Separate contracts will be drafted for Special Needs Plans, describing the participation requirements and payment arrangements for these organizations. Contracts then will be executed with selected plans.

Subtasks

13.1 Draft Special Needs Plan contracts

13.2 Make awards to plans pursuant to contracting process developed in Task 10

13.3 Execute contracts

Task 14: Develop an assignment algorithm for recipients who fail to select a plan (HMO, PHSP, SNP)

Timeframe: June - August 1995

The State will formulate policies for assignment of recipients who do not voluntarily select a plan, and for setting auto-assignment limits for each HMO. The State's options in this task will depend in part on the bidder responses received in Task 9. For example, if the lowest price bidders have ample capacity, the State may wish to design the algorithm to place a large portion of recipients into these HMOs. Once the State has defined its objectives and policies for the algorithm, the State's consultants and actuaries will be responsible for its design.

Subtasks

- 14.1 Identify policy objectives (including any specifically related to networks which include public hospitals)
- 14.2 Establish plan limits on auto assignment
- 14.3 Finalize the assignment algorithm strategy and design
- 14.4 Incorporate algorithm into automated systems (enrollment system)

Task 15: Develop alternatives to HMO/PHSP/SNP enrollment if total plan capacity is inadequate to serve all potential enrollees

Timeframe: July 1995

New York will not attempt to enroll all program beneficiaries into managed care until such time as adequate health plan capacity exists. Should the first round of contracting result in the State's obtaining fewer prepaid health plan "memberships" than are required, an alternate plan will be developed to deal with the shortfall.

Subtasks

- 15.1 Document total health plan capacity by region
- 15.2 Assess capacity against anticipated demand
- 15.3 Document shortfall by region (if any)
- 15.4 Meet with plans to determine if additional capacity could be made available and in what timeframes
- 15.5 Develop fee-for-service, case management and partial capitation alternatives (if needed)
- 15.6 Modify overall implementation plan to accommodate these changes (if necessary)

Task 16: Develop and implement a provider and beneficiary public education program¹

Timeframe: August - September 1995

The State¹ will focus its educational efforts on the public, and on current and potential future program beneficiaries. The State will also work cooperatively with contracted health plans to educate providers about the new system of care delivery and financing and the special needs of the population to be served through this initiative.

Subtasks

- 16.1 Identify State agency personnel to be involved in developing and executing the program
- 16.2 Enlist the support of adult and consumer organizations
- 16.3 Develop a plan of outreach for the State Departments of Social Services and Health
- 16.4 Develop educational materials
- 16.5 Arrange for multi-media support (television, radio, newspapers, billboards, etc.)
- 16.6 Execute a public education campaign
- 16.7 Develop and distribute detailed information on benefits, eligibility criteria and enrollment provisions to current and potential future enrollees
- 16.8 Establish a toll-free information hotline

¹ NOTE: The State may wish to contract these functions to an outside firm

Task 17: Develop an outreach and enrollment process and schedule and conduct enrollment

Timeframe: September - October 1995

After health plan contracts have been awarded, enrollment policies/procedures will be established and arrangements made for program contractors to submit their marketing materials for review by the appropriate local and State agencies. New York may utilize the services of an independent enrollment and benefits counselor (benefit management model). Accordingly, an evaluation of where, and under what circumstances a private enrollment contractor would be used will also be undertaken.

Subtasks

- 17.1 Evaluate operational and financial implications of employing a "benefit management model" under the auspices of a private contractor
- 17.2 Establish enrollment policies and procedures, including the content of the "benefit counseling" session
- 17.3 Specify final phase-in schedule for enrollees (by aid category, geographic region and recertification time frame)
- 17.4 Develop and issue an RFP for a benefit management firm (if this model is to be used in one or more areas)
- 17.4a Evaluate bids from contractors
- 17.4b Select awardee and conduct a site visit
- 17.4c Execute a contract and obtain XCFR approval
- 17.5 Review enrollment/educational information for distribution to eligibles
- 17.6 Implement a training program for State and contractor staff participating in the enrollment process

Task 17: Develop an outreach and enrollment process and schedule and conduct enrollment (continued)

Timeframe: September - October 1995

Subtasks

- 17.7 Generate letters and distribute with enrollment cards to first phase eligibles
- 17.8 Receive and process participant enrollment cards
- 17.9 Generate initial enrollment rosters
- 17.10 Merge toll-free information hotline activated during -up (Task 16) with the general information line to be maintained by the enrollment counseling contractor

Task 18: Prepare and promulgate rules and policy manual and modify State plan

Timeframe: October - December 1995

In Task 18, draft program rules will be developed and program policies and procedures will be outlined. Public hearings will be held in accordance with State policies and revisions made as necessary before developing a full policies and procedures manuals and submitting final rules to the offices of the Attorney General and the Secretary of State.

The last activity within this task will be to submit an updated State plan to HCFA. The State plan must be submitted by the last day of the quarter during which the program begins operations.

Subtasks

- 18.1 Develop draft rules and program policies and procedures
- 18.2 Review draft rules and policies and procedures outline with all appropriate State agency staff with provider consumer communities
- 18.3 Promulgate the policy manual and rules
- 18.4 Draft and submit a State plan amendment to HCFA

Implementation Timeline by Task

Task	Feb-95	Mar-95	Apr-95	May-95	Jun-95	Jul-95	Aug-95	Sep-95	Oct-95	Nov-95	Dec-95
1 Disseminate Draft Concept; Conduct Public Hearings											
2 Develop Process for Ongoing Public Communication											
3 Develop and Submit 1115 Waiver Proposal											
4 Contract for Actuarial and other Technical Assistance											
5 Design and Develop Information Systems Modifications											
6 Evaluate Agency Organizational Structures											
7 Collect and Assemble Database for Capitation Ratesetting											
8 Develop Participation Requirements for Fully Capitated Systems											
9 Prepare Health Plan RFP, Evaluate Proposals and Execute Agreements											
10 Identify Special Program Initiatives											
11 Develop SNP Program Participation Standards											
12 Establish SNP Payment Methodologies											
13 Execute Contracts with SNPs											
14 Develop Assignment Algorithm											
15 Develop Alternatives if Plan Capacity is Inadequate											
16 Develop Provider/Beneficiary Education Program											
17 Develop Outreach/Education Process and Conduct Enrollment											
18 Prepare and Promulgate Rules and Policy Manual; Modify State Plan											

Ongoing Throughout Implementation Process

To Be Determined
To Be Determined
To Be Determined

APPENDIX 5

DETAILED CASELOAD AND COST TABLES

Appendix 5.A
ANNUAL CASELOAD GROWTH

Appendix 5.A
Historical and Projected Annual Caseload

Month	TOTAL DSS + OSA	SSI AGED	SSI BL & DIS	AFDC ADULTS	AFDC&HR CHILDREN	MA-ONLY		MA-ONLY		MA-ONLY		MA-ONLY	
						SSI AGED	SSI BL & DIS	AFDC ADULTS	AFDC&HR CHILDREN	HR ADULTS	HR-REL ADULTS		
1988-89	2,210,548	154,262	248,714	307,933	760,312	147,959	68,792	56,874	230,709	185,767	49,025		
1989-90	2,337,202	155,471	259,588	303,352	772,673	148,917	68,882	71,870	285,653	206,452	64,345		
1990-91	2,541,478	159,707	282,195	326,673	832,158	148,678	72,269	85,547	328,068	244,685	61,499		
1991-92	2,755,995	163,392	321,546	349,699	885,546	151,267	78,029	96,564	368,907	276,465	64,479		
1992-93	2,910,456	168,487	359,105	378,870	925,176	151,492	81,192	100,331	388,460	293,385	63,958		
1993-94	3,064,826	172,716	396,716	403,760	956,556	153,852	86,483	106,290	415,937	301,658	70,857		
1994-95	3,218,707	176,567	424,848	423,909	985,409	157,280	91,458	114,199	464,601	300,062	80,373		
1995-96	3,373,657	181,266	455,883	449,533	1,020,852	157,427	95,511	122,104	507,817	300,642	82,553		
1996-97	3,551,525	185,662	496,720	474,819	1,060,881	157,243	100,468	133,183	557,298	298,728	86,522		
1997-98	3,731,274	189,809	539,806	500,789	1,103,274	157,114	104,522	143,059	605,223	297,193	90,484		
1998-99	3,967,710	194,976	597,860	534,742	1,156,361	157,012	109,692	156,160	669,035	296,557	95,315		
1999-00	4,198,769	199,806	655,027	567,384	1,206,823	156,958	114,624	169,141	733,000	296,039	99,967		

Appendix 5.B
MONTHLY CASELOAD GROWTH

Appendix 5.R
Historical and Projected Monthly Caseload

Month	TOTAL DSS + OSA	SSI AGED	SSI BL & DIS	AFDC ADULTS	AFDC&HR CHILDREN	MA-ONLY	MA-ONLY	MA-ONLY	MA-ONLY	HR ADULTS	MA-ONLY
						SSI AGED	SSI BL & DIS	AFDC ADULTS	AFDC&HR CHILDREN		HR-REL ADULTS
Oct-88	2,171,993	156,443	246,186	312,462	767,017	147,684	66,746	33,193	204,055	178,784	39,423
Nov-88	2,176,398	156,056	247,432	312,803	767,517	147,942	66,806	33,166	205,502	179,622	39,480
Dec-88	2,172,040	155,583	248,375	310,774	763,175	147,491	66,896	33,057	207,313	179,713	39,663
Jan-89	2,200,787	155,726	250,382	311,755	766,095	148,890	68,901	33,329	217,209	182,853	43,447
Feb-89	2,196,278	154,171	250,212	309,731	761,496	147,817	68,767	33,346	221,502	181,367	43,199
Mar-89	2,210,757	153,620	246,519	310,084	763,157	147,717	69,364	36,704	227,378	187,949	48,063
Apr-89	2,226,926	153,593	248,306	309,465	763,226	147,869	69,683	38,261	235,027	189,929	51,467
May-89	2,231,788	153,427	248,699	307,618	754,233	148,123	69,134	38,372	247,031	190,624	53,325
Jun-89	2,239,143	153,513	249,715	306,246	751,569	148,037	70,010	39,605	254,262	191,305	54,111
Jul-89	2,232,517	153,236	249,854	302,378	756,879	147,668	69,947	39,616	246,990	189,763	56,186
Aug-89	2,233,873	153,011	249,143	301,317	756,277	148,057	69,464	39,672	250,226	188,784	57,524
Sep-89	2,234,072	152,768	249,351	300,560	735,367	148,213	69,047	38,966	251,810	188,506	59,444
Oct-89	2,248,636	152,852	250,801	300,594	751,038	149,306	69,664	39,664	255,998	191,633	60,662
Nov-89	2,253,589	153,918	251,771	299,530	737,131	149,264	68,880	39,385	258,153	194,232	61,245
Dec-89	2,260,588	154,114	252,997	299,708	758,401	148,653	68,118	39,486	260,516	196,989	61,606
Jan-90	2,310,812	154,715	255,689	302,236	768,590	149,569	68,515	68,962	275,448	202,544	64,544
Feb-90	2,324,377	155,022	257,831	302,194	770,595	148,715	68,181	70,969	281,605	203,787	65,478
Mar-90	2,349,700	155,670	259,319	304,171	775,663	148,819	68,632	73,756	288,644	207,772	67,252
Apr-90	2,359,876	155,630	261,681	304,222	775,797	149,178	68,560	75,291	292,863	209,319	67,335
May-90	2,359,619	155,000	261,602	302,402	772,449	149,310	76,711	76,711	296,678	210,459	66,123
Jun-90	2,371,363	155,472	262,789	302,954	775,547	148,892	69,066	78,223	300,293	212,209	65,948
Jul-90	2,387,475	156,775	264,791	304,966	781,167	148,797	69,239	79,162	303,541	214,244	64,793
Aug-90	2,403,323	157,802	266,769	307,507	787,354	148,411	69,779	80,114	305,597	216,383	63,607
Sep-90	2,417,145	158,686	2—50	309,735	791,337	148,093	69,731	80,715	308,500	217,849	63,549
Oct-90	2,438,275	159,463	270,517	312,296	796,862	148,086	70,102	82,221	313,617	221,228	63,883
Nov-90	2,449,745	159,515	271,833	315,022	101,667	147,162	70,245	82,654	314,911	224,919	61,747
Dec-90	2,466,132	159,709	273,595	318,028	807,519	146,783	70,734	82,545	315,894	230,017	61,308
Jan-91	2,497,370	159,592	276,234	321,288	818,325	147,174	70,820	84,576	322,029	235,446	61,116
Feb-91	2,516,737	159,343	278,480	3 w 5	824,984	147,293	71,119	85,683	325,154	238,595	61,741
Mar-91	2,539,279	159,254	281,203	327,619	833,032	148,019	71,806	85,313	327,727	244,235	61,071
Apr-91	2,557,452	159,515	284,084	329,152	838,109	148,306	71,560	86,019	330,858	249,180	60,669
May-91	2,573,436	159,296	284,536	330,350	843,388	148,777	73,037	86,797	333,512	253,486	60,257
Jun-91	2,588,461	159,616	287,726	331,303	847,122	149,762	73,782	87,075	335,407	256,038	60,630
Jul-91	2,610,572	160,274	335,156	335,156	854,334	150,665	74,329	87,690	337,664	257,871	61,320
Aug-91	2,626,343	160,298	337,791	337,791	859,594	151,157	74,773	87,934	339,072	261,941	61,292
Sep-91	2,633,893	160,539	294,739	337,727	860,557	150,950	74,915	88,061	340,965	263,260	62,180
Jan-92	2,705,173	161,699	307,235	348,636	878,156	151,366	76,077	90,547	351,367	275,416	64,674
Feb-92	2,717,189	161,586	310,321	349,168	880,159	150,721	76,162	92,208	355,746	276,055	65,063
Mar-92	2,740,362	162,188	314,742	349,729	883,902	151,105	77,033	94,909	363,555	277,412	65,787
Apr-92	2,741,736	162,357	317,672	347,450	881,722	151,011	77,744	96,481	367,093	275,095	65,111
May-92	2,752,813	163,471	321,839	346,697	880,971	151,048	78,448	98,166	371,897	275,440	64,836
Jun-92	2,765,777	164,177	325,790	347,150	883,574	151,265	78,889	99,222	375,283	275,837	64,590
Jul-92	2,777,960	164,546	328,219	349,898	888,921	151,330	79,113	99,293	376,532	276,420	63,688
Aug-92	2,794,668	165,030	332,664	352,865	893,927	151,717	79,340	99,380	378,940	276,962	63,843
Sep-92	2,808,275	165,470	335,436	355,702	894,583	151,839	79,455	98,872	379,748	279,547	63,623
Oct-92	2,828,738	166,460	338,418	359,523	905,317	151,591	79,333	98,596	380,662	285,232	63,529
Nov-92	2,839,219	167,066	342,142	361,658	907,824	151,350	79,437	97,567	380,267	287,410	63,798
Dec-92	2,850,584	167,309	345,501	371,629	910,954	150,903	80,095	97,333	380,392	282,598	63,870
Jan-93	2,870,739	167,549	349,386	374,875	916,175	150,975	79,878	98,004	382,742	286,868	64,217
Feb-93	2,886,467	167,725	353,669	376,793	918,959	151,239	80,510	98,837	384,156	290,075	64,504
Mar-93	2,913,875	168,144	331,342	380,322	926,176	151,412	81,152	100,062	387,815	296,514	64,936
Apr-93	2,930,765	168,459	361,219		930,044	151,195	81,243	101,212	389,654	300,056	64,894
May-93	2,945,286	168,974	365,755	384,355	932,083	151,333	81,764	102,381	393,160	300,900	64,511
Jun-93	2,949,867	169,348	368,425	386,232	933,984	151,561	82,069	102,582	393,679	298,110	63,677
Jul-93	2,959,332	169,895	372,241	387,750	937,206	151,665	82,400	102,419	394,677	298,036	63,063
Aug-93	2,974,179		376,079	389,929	941,404	152,260	83,036	102,484	396,909	298,492	63,256
Sep-93	2,976,397	170,634	378,179	390,584	941,909	152,409	83,383	102,499	397,412	296,329	63,059
Oct-93	2,991,131	171,329	382,123	392,165	945,526	152,644	83,972	102,687	391,891	298,082	63,712
Nov-93	2,989,495	171,907	384,536	393,339	944,793	152,473	84,131	101,402	396,350	296,371	64,193

Appendix S.B
Historical and Projected Monthly Caseload

Month	TOTAL	SSI	SSI	AFDC	AFDC&HR	MA-ONLY	MA-ONLY	MA-ONLY	MA-ONLY	HIR	MA-ONLY
	DSS + OSA	AGED	BL & DIS	ADULTS	CHILDREN	SSI	SSI	AFDC	AFDC&HR		HR-REL
Dec-93	3,001,645	172,117	386,398	398,272	948,706	152,431	84,627	101,129	396,347	295,953	63,663
Jan-94	3,020,550	172,397	390,094	400,818	951,282	152,384	84,271	102,188	400,901	299,051	67,164
Feb-94	3,040,527	172,297	392,649	401,984	952,641	152,819	83,052	105,276	408,513	299,963	69,333
Mar-94	3,072,603	172,444	393,470	406,038	959,855	133,375	86,318	107,213	415,221	305,037	71,614
Apr-94	3,087,205	172,457	398,247	407,003	961,665	153,632	86,957	107,837	418,515	308,594	72,298
May-94	3,101,447	172,921	401,451	408,461	962,014	154,049	87,645	108,906	424,329	307,500	73,951
Jun-94	3,103,073	173,279	403,926	408,430	960,590	154,270	87,892	108,976	427,269	303,807	74,634
Jul-94	3,115,449	173,544	406,658	409,161	962,547	115,314	88,767	109,273	431,840	302,913	75,412
Aug-94	3,124,032	173,806	408,883	409,380	963,631	156,150	89,062	110,051	435,377	301,775	75,917
Sep-94	3,130,758	174,094	410,157	410,034	965,416	156,660	89,128	110,536	437,472	300,848	76,393
Oct-94	3,143,406	174,533	412,332	411,996	968,694	156,910	90,004	110,847	441,205	299,736	77,148
Nov-94	3,148,086	174,813	414,214	413,505	969,065	156,995	89,688	111,019	443,553	297,730	77,504
Dec-94	3,165,915	175,160	416,718	416,114	974,230	157,225	90,492	111,701	448,281	297,560	78,376
Jan-95	3,179,343	175,606	418,283	418,994	976,814	157,460	90,826	112,215	456,751	299,159	79,229
May-95	3,245,504	176,879	427,368	428,135	990,913	157,129	91,752	115,580	470,674	304,916	12,160
Jun-95	3,254,310	177,340	429,903	429,673	992,762	157,195	92,127	116,131	475,022	302,233	81,924
Jul-95	3,266,818	177,732	432,186	430,620	995,745	157,415	92,358	116,325	480,110	301,748	82,559
Aug-95	3,277,799	178,271	434,830	432,131	998,831	157,435	92,829	116,797	485,052	299,226	82,346
Sep-95	3,287,141	178,734	437,799	434,016	1,001,629	157,601	93,044	117,176	486,758		82,108
Oct-95	3,294,131	179,164	440,095	435,459	1,004,850	157,927	93,531	118,002	486,986	296,524	81,593
Nov-95	3,299,921	179,627	442,313	437,568	1,005,965	157,906	93,381	118,091	489,454	294,768	80,847
Dec-95	3,318,327	179,978	445,448	441,224	1,010,975	157,749	94,031	118,517	493,499	295,1647	81,239
Jan-96	3,329,815	180,469	447,702	444,182	1,013,864	157,665	94,454	118,833	494,812	296,652	81,161
Feb-96	3,350,410	180,836	450,958	446,360	1,017,082	157,523	94,699	120,899	499,323	300,970	81,758
Mar-96	3,373,327	181,176	454,224	450,082	1,021,181	157,117	95,228	122,109	504,269	303,095	82,345
Apr-96	3,381,169	181,489	456,657	452,835	1,023,338	157,340	95,580	122,752	509,162	306,332	82,687
May-96	3,402,598	181,815	460,120	454,799	1,025,974	157,107	96,311	123,543	514,601	304,947	63,374
Jun-96	3,413,139	182,119	463,287	456,107	1,026,962	157,086	96,874	124,087	518,888	304,327	83,401
Jul-96	3,426,537	182,468	466,482	457,444	1,030,343	157,094	97,117	124,982	523,692	302,913	83,988
Aug-96	3,437,561	182,836	469,985	458,481	1,033,107	157,115	97,740	126,129	527,708	300,457	84,002
Sep-96	3,450,154	183,213	473,310	459,860	1,036,586	157,194	98,025	127,284	531,400	299,066	84,215
Oct-96	3,463,542	183,587	476,694	461,824	1,040,377	157,299	98,480	128,322	535,044	297,556	84,355
Nov-96	3,476,115	183,962	480,355	464,068	1,043,221	157,341	98,823	129,278	538,548	296,175	84,414
Dec-96	3,493,421	184,337	483,762	466,609	1,048,254	157,393	99,176	130,246	542,391	296,208	85,039
Jan-97	3,508,807	184,714	487,135	469,279	1,051,652	157,391	99,583	131,154	546,205	296,460	85,233
Feb-97	3,527,090	185,091	490,887	471,782	1,055,395	157,374	99,890	131,945	550,280	298,467	85,939
Mar-97	3,545,482	185,469	494,340	474,150	1,059,537	157,354	100,298	132,781	554,557	300,557	86,439
Apr-97	3,561,884	185,847	498,302	476,448	1,062,638	157,301	100,631	133,583	558,937	301,345	86,846
May-97	3,577,307	186,227	502,177	478,748	1,066,340	157,176	101,010	134,421	563,423	300,838	87,448
Jun-97	3,592,269	186,607	505,745	480,677	1,069,394	157,131	101,379	135,268	567,169	300,602	87,596
Jul-97	3,608,758	186,988	509,874	482,619	1,073,931	157,063	101,738	136,139	572,346	299,934	88,127
Aug-97	3,623,489	187,370	513,684	484,672	1,077,821	157,048	102,126	137,041	576,786	298,695	88,247
Sep-97	3,639,575	187,752	517,686	486,954	1,082,010	157,044	102,485	137,969	581,189	297,903	88,583
Oct-97	3,655,934	188,135	521,894	489,432	1,086,160	157,051	102,872	138,913	585,584	297,036	88,857
Nov-97	3,671,614	188,519	525,771	492,106	1,089,748	157,071	103,244	139,863	589,979		89,095
Dec-97	3,689,167	188,904	529,932	494,863	1,094,466	151,119	103,624	140,111	594,421	296,093	89,627
Jan-98	3,706,867	189,290	534,185	497,578	1,098,015	157,135	104,007	141,775	598,901	296,123	89,858
Feb-98	3,725,208	189,676	538,181	500,204	1,101,921	157,169	104,384	142,731	603,438	297,062	90,441
Mar-98	3,743,791	190,064	542,402	502,720	1,106,017	157,173	104,773	143,646	608,037	298,126	90,794
Apr-98	3,761,293	190,452	546,674	505,155	1,109,573	157,170	105,154	144,642	612,692	298,609	91,170
May-98	3,778,587	190,840	550,773	507,590	1,113,622	157,132	105,542	145,601	617,398	298,451	91,636
Sep-98	3,848,308	192,404	568,439	517,449	1,129,946	157,009	107,100	149,503	636,560	297,017	92,879
Oct-98	3,865,790	192,796	572,742	520,114	1,133,999	156,992	107,494	150,502	641,421	296,527	93,203
Nov-98	3,883,326	193,190	577,235	522,838	1,137,802	156,911	107,888	151,504	646,312	296,050	93,522
Dec-98	3,902,217	193,584	581,872	525,568	1,142,241	156,992	108,285	152,521	651,239	295,911	94,003
Jan-99	3,920,811	193,980	586,221	528,265	1,145,967	156,996	108,683	153,542	656,202	295,868	94,287
Feb-99	3,939,165	194,376	590,852	530,905	1,150,051	157,021	109,081	154,569	661,206	296,296	94,809
Mar-99	3,958,306	194,772	595,481	533,493	1,154,230	157,025	109,482	155,603	666,251	296,830	95,139
Apr-99	3,976,874	195,170	599,946	536,039	1,158,142	157,042	109,884	156,643	671,339	297,110	95,540

Appendix 5.B
Historical and Projected Monthly Caseload

Month	TOTAL DSS + OSA	SSI AGED	SSI BL & DSS	AFDC ADULTS	AFDC&HR CHILDREN	MA-ONLY SSI AGED	MA-ONLY SSI BL & DSS	MA-ONLY AFDC ADULTS	MA-ONLY AFDC&HR CHILDREN	HR ADULTS	MA-ONLY HR-REL ADULTS
May-99	3,995,783	195,568	604,660	538,639	1,162,393	157,037	110,288	157,689	676,469	297,077	95,963
Jun-99	4,014,368	195,968	609,285	541,249	1,166,449	157,039	110,693	158,741	681,640	297,068	96,236
Jul-99	4,033,457	196,368	613,870	543,898	1,170,915	157,020	111,099	159,800	686,851	296,932	96,705
Aug-99	4,052,139	196,769	618,741	546,577	1,174,970	157,013	111,507	160,866	692,101	296,625	96,970
Sep-99	4,071,085	197,170	623,417	549,300	1,179,175	156,988	111,917	161,940	697,390	296,386	97,403
Oct-99	4,090,031	197,573	628,126	552,062	1,183,353	156,975	112,328	163,020	702,718	296,113	97,763
Nov-99	4,109,184	197,976	633,041	554,855	1,187,448	156,956	112,740	164,108	708,085	295,839	98,136
Dec-99	4,128,783	198,380	637,727	557,648	1,191,982	156,951	113,154	165,203	713,492	295,728	98,597
Jan-00	4,148,137	198,785	642,631	560,427	1,195,933	156,943	113,570	166,306	718,941	295,673	98,929
Feb-00	4,168,277	199,191	647,582	563,187	1,200,254	156,930	113,987	167,417	724,430	295,560	99,418
Mar-00	4,188,210	199,598	652,341	565,938	1,204,598	156,947	114,405	168,535	729,963	296,123	99,762
Apr-00	4,208,316	200,003	657,368	568,695	1,208,802	156,959	114,826	169,660	735,538	296,279	100,185
May-00	4,228,460	200,414	662,321	571,475	1,213,216	156,959	115,247	170,793	741,156	296,284	100,595
Jun-00	4,248,439	200,823	667,212	574,288	1,217,500	156,968	115,670	171,933	746,817	296,293	100,933
Jul-00	4,268,986	201,133	672,329	577,134	1,221,998	156,964	116,095	173,081	752,522	296,235	101,395
Aug-00	4,288,992	201,644	677,305	580,006	1,226,241	156,967	116,522	174,236	758,271	296,084	101,717
Sep-00	4,309,488	202,055	682,337	582,898	1,230,624	156,956	116,949	175,400	764,063	295,956	102,170

Appendix 5.B
Historical and Projected Monthly Caseload - Percent Change

Month	TOTAL DSS + OSA	SSI AGED	SSI BL & DIS	AFDC ADULTS	AFDC&HR CHILDREN	MA-ONLY SSI AGED	MA-ONLY SSI BL & DIS	MA-ONLY AFDC ADULTS	MA-ONLY AFDC&HR CHILDREN	HR ADULTS	MA-ONLY HR-REL ADULTS
Oct-88											
Nov-88	0.20%	-0.25%	0.51%	0.11%	0.07%	0.17%	0.09%	-0.05%	0.7196	0.47%	0.14%
Dec-88	-0.20%	-0.30%	0.38%	-0.65%	-0.57%	-0.30%	0.13%	-0.21%	0.88%	0.05%	0.46%
Jan-89	1.32%	0.09%	0.81%	0.32%	0.38%	0.95%	3.00%	4.66%	4.77%	1.75%	954%
Feb-89	-0.20%	-1.00%	-0.07%	-0.64%	-0.61%	-0.72%	-0.19%	0.57%	1.98%	-0.81%	4.47%
Mar-89	0.66%	-0.36%	-1.48%	0.11%	0.22%	-0.07%	0.87%	1.54%	2.74%	3.63%	5.90%
Apr-89	0.73%	-0.02%	0.72%	-0.20%	0.02%	0.10%	0.46%	2.75%	3.27%	1.05%	7.08%
May-89	0.22%	-0.11%	0.16%	-0.60%	-1.19%	0.17%	0.22%	1.05%	5.11%	0.37%	3.61%
Jun-89	0.33%	0.06%	0.41%	-0.45%	-0.35%	-0.06%	0.25%	1.25%	2.92%	0.36%	2.92%
Jul-89	-0.30%	-0.18%	0.06%	-1.26%	0.71%	-0.25%	-0.09%	0.02%	-2.88%	-0.81%	2.38%
Aug-89	0.06%	-0.15%	-0.12%	-0.35%	-0.08%	0.26%	-0.69%	0.09%	1.31%	-0.52%	2.38%
Sep-89	0.01%	-0.16%	-0.08%	-0.25%	-0.12%	0.11%	-0.54%	-1.18%	0.63%	-0.15%	3.34%
Oct-89	0.65%	0.05%	0.58%	0.01%	0.35%	0.74%	0.00%	1.18%	1.66%	1.66%	2.05%
Nov-89	0.22%	0.70%	0.39%	-0.35%	-0.12%	-0.03%	-0.30%	-0.47%	0.84%	1.36%	0.96%
Dec-89	0.31%	0.13%	0.49%	0.06%	0.17%	-0.41%	-1.11%	0.17%	0.92%	1.42%	0.59%
Jan-90	2.22%	0.39%	1.06%	0.84%	1.34%	0.62%	0.58%	15.93%	5.73%	2.82%	4.77%
Feb-90	0.59%	0.20%	0.84%	-0.01%	0.26%	-0.57%	-0.49%	291%	224%	0.61%	1.45%
Mar-90	1.09%	0.42%	0.58%	0.65%	0.66%	0.07%	0.66%	3.93%	2.50%	1.96%	2.71%
Apr-90	0.43%	-0.03%	0.91%	0.02%	0.02%	0.24%	-0.10%	2.08%	1.46%	0.74%	0.12%
May-90	-0.01%	-0.40%	0.01%	-0.60%	-0.43%	0.09%	0.34%	1.89%	1.30%	0.54%	-1.80%
Jun-90	0.50%	0.30%	0.41%	0.18%	0.40%	-0.28%	0.40%	1.97%	1.22%	0.83%	-0.26%
Jul-90	0.68%	0.84%	0.77%	0.66%	0.72%	-0.06%	0.25%	1.20%	1.08%	0.96%	-1.75%
Aug-90	0.66%	0.66%	0.75%	0.83%	0.79%	-0.26%	0.78%	1.20%	0.68%	1.00%	-1.83%
Sep-90	0.58%	0.56%	0.82%	0.72%	0.51%	-0.21%	-0.07%	0.75%	0.95%	0.68%	4.11%
Oct-90	0.87%	0.49%	0.58%	0.83%	0.70%	0.00%	0.53%	1.87%	1.66%	1.55%	0.53%
Nov-90	0.47%	0.08%	0.49%	0.87%	0.60%	-0.62%	0.20%	0.53%	0.41%	1.67%	-3.34%
Dec-90	0.67%	0.08%	0.65%	0.93%	0.73%	-0.26%	0.70%	-0.13%	0.31%	2.27%	-0.71%
Jan-91	1.27%	-0.07%	0.96%	1.03%	1.34%	0.27%	0.12%	2.46%	1.94%	236%	0.94%
Feb-91	0.78%	-0.16%	0.81%	0.95%	0.81%	0.08%	0.42%	1.31%	0.97%	1.34%	-0.23%
Mar-91	0.90%	-0.06%	0.98%	1.01%	0.98%	0.49%	0.97%	-0.43%	0.79%	2.36%	-1.09%
Apr-91	0.72%	0.16%	1.02%	0.47%	0.61%	0.19%	-0.34%	0.83%	0.96%	2.02%	-0.66%
May-91	0.62%	9.14%	0.16%	0.36%	0.63%	0.32%	2.06%	0.90%	0.80%	1.73%	-0.68%
Jun-91	0.58%	0.20%	1.12%	0.29%	0.44%	0.66%	1.02%	0.32%	0.57%	1.01%	0.62%
Jul-91	0.85%	0.41%	1.23%	1.16%	0.85%	0.60%	0.74%	0.71%	0.67%	0.72%	1.14%
Aug-91	0.61%	0.01%	0.29%	0.79%	0.66%	0.33%	0.60%	0.28%	0.42%	1.58%	-0.05%
Sep-91	0.29%	0.15%	0.89%	-0.02%	0.07%	-0.14%	0.19%	0.14%	0.56%	0.50%	1.45%
Jan-92	0.76%	0.00%	0.96%	0.34%	0.37%	0.22%	0.54%	2.52%	1.68%	1.24%	1.19%
Feb-92	0.44%	-0.07%	1.00%	0.15%	0.23%	4.43%	0.11%	1.83%	1.25%	0.23%	0.60%
Mar-92	0.85%	0.37%	1.42%	0.16%	0.43%	0.25%	1.14%	2.93%	2.20%	0.49%	1.11%
Apr-92	0.05%	0.10%	0.93%	-0.65%	-0.25%	-0.06%	0.92%	1.66%	0.97%	-0.84%	-1.03%
May-92	0.40%	0.69%	1.31%	O . m	-0.09%	0.02%	0.91%	1.78%	1.31%	0.13%	-0.42%
Jun-92	0.47%	0.43%	1.23%	0.13%	0.30%	0.14%	0.56%	1.08%	0.91%	0.14%	-0.38%
Jul-92	0.44%	0.22%	0.75%	0.79%	0.61%	0.04%	0.28%	0.07%	0.33%	0.21%	-1.40%
Aug-92	0.60%	0.29%	1.35%	0.85%	0.56%	0.26%	0.29%	0.09%	0.64%	0.20%	0.24%
Sep-92	0.49%	0.27%	0.83%	0.80%	0.52%	0.08%	0.14%	-0.51%	0.21%	0.93%	-0.34%
Oct-92	0.73%	0.60%	0.89%	1.07%	0.76%	-0.16%	-0.15%	-0.28%	0.24%	2.03%	-0.15%
Nov-92	0.37%	0.36%	1.31%	0.59%	0.27%	-0.16%	0.13%	-1.04%	-0.10%	0.76%	0.42%
Dec-92	0.40%	0.15%	0.78%	276%	0.34%	-0.30%	0.83%	-0.24%	0.08%	-1.67%	0.11%
Jan-93	0.71%	0.14%	1.12%	0.87%	0.57%	0.05%	-0.27%	0.69%	0.62%	15 18	0.65%
Feb-93	0.55%	0.11%	1.23%	0.51%	0.30%	0.17%	0.79%	0.85%	0.37%	1.12%	0.34%
Mar-93	0.95%	0.25%	1.04%	0.94%	0.79%	0.11%	0.80%	1.24%	0.95%	2.22%	0.67%
Apr-93	a 5 m	0.19%	1.08%	0.65%	0.42%	-0.14%	0.11%	1.15%	0.47%	1.19%	-0.06%
May-93	0.50%	0.31%	1.26%	0.41%	0.22%	0.09%	0.64%	1.16%	0.90%	0.28%	-0.48%
Jun-93	0.16%	0.22%	0.78%	0.49%	0.20%	0.15%	0.37%	0.20%	0.13%	-0.93%	-1.40%
Jul-93	0.32%	0.32%	0.98%	0.39%	0.34%	0.07%	0.40%	-0.16%	0.25%	-0.02%	-0.96%
Aug-93	0.50%	0.23%	1.03%	0.56%	0.45%	0.39%	0.77%	0.06%	0.57%	0.15%	0.37%
Sep-93	0.07%	0.20%	0.56%	0.17%	0.05%	0.10%	0.42%	0.01%	0.13%	-0.72%	-0.37%
Oct-93	0.50%	0.41%	1.04%	0.40%	0.38%	0.15%	0.71%	0.18%	0.37%	0.59%	1.04%
Nov-93	-0.05%	0.34%	0.63%	0.30%	-0.08%	-0.11%	0.19%	-1.25%	-0.64%	-0.57%	0.75%

Appendix 5.B
Historical and Projected Monthly Caseload - Percent Change

Month	TOTAL DSS + OSA	SSI AGED	SSI BL & DIS	AFDC ADULTS	AFDC&HR CHILDREN	MA-ONLY SSI AGED	MA-ONLY SSI BL & DIS	MA-ONLY AFDC ADULTS	MA-ONLY AFDC&HR CHILDREN	HR ADULTS	MA-ONLY HR-REL ADULTS
Dec-93	0.41%	0.12%	0.48%	1.23%	0.41%	-0.03%	0.59%	-0.27%	0.00%	-0.14%	2.29%
Jan-94	0.63%	0.16%	0.96%	0.68%	0.27%	-0.03%	-0.42%	1.05%	1.15%	1.05%	2.28%
Feb-94	0.66%	-0.06%	0.65%	0.29%	0.14%	0.29%	0.93%	3.02%	1.90%	0.30%	3.23%
Mar-94	1.06%	0.09%	0.72%	1.01%	0.76%	0.36%	1.49%	1.84%	1.64%	1.69%	3.29%
Apr-94	0.48%	0.01%	0.70%	0.23%	0.19%	0.17%	0.74%	0.58%	0.79%	1.17%	0.96%
May-94	0.46%	0.27%	0.80%	0.36%	0.04%	0.28%	0.79%	0.99%	1.44%	-0.35%	2.29%
Jun-94	0.05%	0.21%	0.62%	0.01%	-0.15%	0.13%	0.28%	0.06%	0.63%	-1.20%	0.92%
Jul-94	0.40%	0.15%	0.68%	0.18%	0.20%	0.68%	1.00%	0.27%	1.07%	-0.29%	1.04%
Aug-94	0.28%	0.15%	0.55%	0.05%	0.11%	0.54%	0.33%	0.71%	0.81%	-0.38%	0.67%
Sep-94	0.22%	0.17%	0.31%	0.16%	0.19%	0.33%	0.07%	0.44%	0.48%	-0.31%	0.63%
Oct-94	0.40%	0.25%	0.53%	0.47%	0.34%	0.16%	0.98%	0.28%	0.85%	-0.37%	0.99%
Nov-94	0.15%	0.16%	0.46%	0.37%	0.04%	0.05%	-0.35%	0.16%	0.53%	-0.67%	0.46%
Dec-94	0.57%	0.20%	0.60%	0.63%	0.53%	0.21%	0.90%	0.61%	1.07%	-0.06%	1.13%
Jan-95	0.42%	0.25%	0.38%	0.69%	0.27%	0.09%	0.37%	0.46%	0.55%	0.54%	1.09%
May-95	0.39%	0.21%	0.67%	0.50%	0.30%	-0.05%	0.39%	0.62%	0.96%	-0.67%	1.11%
Jun-95	0.27%	0.26%	0.59%	0.36%	0.19%	0.04%	0.41%	0.48%	0.92%	-0.88%	-0.29%
Jul-95	0.38%	0.23%	0.53%	0.22%	0.30%	0.14%	0.25%	0.17%	1.07%	-0.16%	0.70%
Aug-95	0.34%	0.29%	0.61%	0.35%	0.31%	0.05%	0.51%	0.41%	1.03%	-0.84%	-0.26%
Sep-95	0.29%	0.27%	0.68%	0.44%	0.28%	0.08%	0.23%	0.32%	0.3%	-0.33%	-0.25%
Oct-95	0.21%	0.23%	0.52%	0.33%	0.32%	0.20%	0.52%	0.71%	0.05%	-0.58%	-0.63%
Nov-95	0.18%	0.26%	0.50%	0.48%	0.11%	-0.01%	-0.16%	0.08%	0.51%	-0.59%	-0.91%
Dec-95	0.56%	0.20%	0.71%	0.84%	0.50%	-0.10%	0.70%	0.36%	0.83%	0.30%	0.51%
Jan-96	0.35%	0.27%	0.51%	0.67%	0.29%	-0.05%	0.45%	0.28%	0.27%	0.34%	-0.12%
Feb-96	0.62%	0.20%	0.73%	0.49%	0.32%	-0.09%	0.26%	1.72%	0.91%	1.46%	0.73%
Mar-96	0.68%	0.19%	0.72%	0.83%	0.40%	-0.07%	0.56%	1.00%	0.99%	1.37%	0.72%
Apr-96	0.45%	0.17%	0.54%	0.61%	0.21%	-0.05%	0.37%	0.53%	0.97%	0.41%	0.41%
May-96	0.43%	0.18%	0.76%	0.43%	0.26%	-0.15%	0.77%	0.64%	1.07%	-0.45%	0.83%
Jun-96	0.31%	0.17%	0.69%	0.29%	0.10%	-0.01%	0.58%	0.44%	0.83%	-0.20%	0.03%
Jul-96	0.39%	0.19%	0.69%	0.29%	0.33%	0.01%	0.25%	0.72%	0.93%	-0.46%	0.70%
Aug-96	0.32%	0.20%	0.75%	0.23%	0.27%	0.01%	0.64%	0.92%	0.77%	-0.81%	0.02%
Sep-96	0.37%	0.21%	0.71%	0.30%	0.34%	0.05%	0.29%	0.92%	0.70%	-0.46%	0.25%
Oct-96	0.39%	0.20%	0.71%	0.43%	0.37%	0.07%	0.46%	0.82%	0.69%	-0.31%	0.17%
Nov-96	0.37%	0.20%	0.77%	0.49%	0.27%	0.03%	0.35%	0.74%	0.65%	-0.46%	0.07%
Dec-96	0.50%	0.20%	0.71%	0.55%	0.48%	0.04%	0.36%	0.75%	0.71%	0.01%	0.74%
Jan-97	0.44%	0.20%	0.70%	0.57%	0.32%	0.00%	0.41%	0.70%	0.70%	0.09%	0.23%
Feb-97	0.52%	0.20%	0.77%	0.53%	0.36%	-0.01%	0.31%	0.63%	0.75%	0.68%	0.83%
Mar-97	0.52%	0.20%	0.70%	0.50%	0.39%	-0.01%	0.41%	0.60%	0.78%	0.70%	0.58%
Apr-97	0.46%	0.20%	0.80%	0.48%	0.29%	-0.03%	0.33%	0.61%	0.79%	0.26%	0.47%
May-97	0.45%	0.20%	0.78%	0.48%	0.35%	-0.08%	0.38%	0.62%	0.80%	-0.17%	0.69%
Jun-97	0.40%	0.20%	0.71%	0.40%	0.29%	-0.03%	0.37%	0.63%	0.79%	-0.08%	0.17%
Jul-97	0.46%	0.20%	0.82%	0.40%	0.42%	-0.04%	0.35%	0.64%	0.79%	-0.22%	0.61%
Aug-97	0.41%	0.20%	0.75%	0.43%	0.36%	-0.01%	0.38%	0.66%	0.78%	-0.41%	0.14%
Sep-97	0.44%	0.20%	0.78%	0.47%	0.39%	0.00%	0.35%	0.68%	0.78%	-0.27%	0.38%
Oct-97	0.45%	0.20%	0.81%	0.51%	0.38%	0.00%	0.38%	0.68%	0.76%	-0.29%	0.31%
Nov-97	0.43%	0.20%	0.74%	0.55%	0.33%	0.01%	0.36%	0.68%	0.75%	-0.28%	0.27%
Dec-97	0.50%	0.20%	0.79%	0.56%	0.43%	0.03%	0.37%	0.68%	0.75%	-0.04%	0.60%
Jan-98	0.46%	0.20%	0.80%	0.55%	0.32%	0.01%	0.37%	0.68%	0.71%	0.01%	0.26%
Feb-98	0.49%	0.20%	0.75%	0.53%	0.36%	0.02%	0.36%	0.67%	0.76%	0.32%	0.65%
Mar-98	0.50%	0.20%	0.78%	0.58%	0.37%	0.00%	0.37%	0.67%	0.76%	0.36%	0.39%
Apr-98	0.47%	0.20%	0.79%	0.48%	0.32%	0.00%	0.36%	0.67%	0.77%	0.16%	0.41%
May-98	0.46%	0.20%	0.75%	0.48%	0.36%	-0.02%	0.37%	0.66%	0.77%	-0.05%	0.51%
Sep-98	0.46%	0.20%	0.81%	0.50%	0.37%	-0.02%	0.37%	0.67%	0.77%	-0.15%	0.42%
Oct-98	0.45%	0.20%	0.76%	0.51%	0.36%	-0.01%	0.37%	0.67%	0.76%	-0.16%	0.35%
Nov-98	0.45%	0.20%	0.78%	0.52%	0.34%	-0.01%	0.37%	0.67%	0.76%	-0.16%	0.34%
Dec-98	0.49%	0.20%	0.80%	0.52%	0.39%	0.01%	0.37%	0.67%	0.76%	-0.05%	0.51%
Jan-99	0.46%	0.20%	0.73%	0.51%	0.33%	0.00%	0.37%	0.67%	0.76%	-0.01%	0.30%
Feb-99	0.49%	0.20%	0.79%	0.58%	0.36%	0.02%	0.37%	0.67%	0.76%	0.14%	0.55%
Mar-99	0.49%	0.20%	0.78%	0.49%	0.36%	0.00%	0.37%	0.67%	0.76%	0.18%	0.35%
Apr-99	0.47%	0.20%	0.75%	0.48%	0.34%	0.01%	0.37%	0.67%	0.76%	0.09%	0.42%

Appendix 5.B
Historical and Projected Monthly Caseload - Percent Change

Month	TOTAL DSS + O&A	SSI AGED	SSI BL & DIS	AFDC ADULTS	AFDC&HR CHILDREN	MA-ONLY		MA-ONLY		MA-ONLY		MA-ONLY	
						SSI AGED	SSI BL & DIS	AFDC ADULTS	AFDC&HR CHILDREN	HR ADULTS	HR-REL ADULTS		
May-99	0.48%	0.20%	0.79%	0.48%	0.37%	0.00%	0.37%	0.67%	0.76%	-0.01%	0.44%		
Jun-99	0.47%	0.20%	0.76%	0.48%	0.35%	0.00%	0.37%	0.67%	0.76%	0.00%	0.28%		
Jul-99	0.48%	0.20%	0.75%	0.49%	0.38%	-0.01%	0.37%	0.67%	0.76%	-0.05%	0.49%		
Aug-99	0.46%	0.20%	0.79%	0.49%	0.35%	0.00%	0.37%	0.67%	0.76%	-0.10%	0.27%		
Sep-99	0.47%	0.20%	0.76%	0.50%	0.36%	-0.02%	0.37%	0.67%	0.76%	-0.08%	0.45%		
Oct-99	0.47%	0.20%	0.76%	0.50%	0.35%	-0.01%	0.37%	0.67%	0.76%	-0.09%	0.37%		
Nov-99	0.47%	0.20%	0.78%	0.51%	0.35%	-0.01%	0.37%	0.67%	0.76%	-0.09%	0.38%		
Dec-99	0.48%	0.20%	0.74%	0.50%	0.38%	0.00%	0.37%	0.67%	0.76%	-0.04%	0.47%		
Jan-00	0.47%	0.20%	0.77%	0.50%	0.34%	-0.01%	0.37%	0.67%	0.76%	-0.02%	0.34%		
Feb-00	0.49%	0.20%	0.77%	0.49%	0.36%	0.00%	0.37%	0.67%	0.76%	0.06%	0.49%		
Mar-00	0.48%	0.20%	0.73%	0.49%	0.36%	0.00%	0.37%	0.67%	0.76%	0.09%	0.35%		
Apr-00	0.48%	0.20%	0.77%	0.49%	0.35%	0.01%	0.37%	0.67%	0.76%	0.05%	0.42%		
May-00	0.48%	0.20%	0.75%	0.49%	0.37%	0.00%	0.37%	0.67%	0.76%	0.00%	0.41%		
Jun-00	0.47%	0.20%	0.74%	0.49%	0.35%	0.01%	0.37%	0.67%	0.76%	0.00%	0.34%		
Jul-00	0.48%	0.20%	0.77%	0.50%	0.37%	0.00%	0.37%	0.67%	0.76%	-0.02%	0.46%		
	0.47%	0.20%	0.74%	0.50%	0.35%	0.00%	0.37%	0.67%	0.76%	-0.05%	0.32%		
Sep-00	0.48%	0.20%	0.74%	0.50%	0.36%	-0.01%	0.37%	0.67%	0.76%	4.04%	0.45%		

Appendix 5.B
Projected Monthly Enrollment

Month	TOTAL ELIGIBLES	EXEMPT ELIGIBLES	TARGET POP.	MANDATORY ENROLLMENT	NOT ENROLLED
Oct-95	3,294,131	537,751	2,756,380	612,103	2,144,277
Nov-95	3,299,921	538,776	2,761,145	688,638	2,072,507
Dec-95	3,318,327	540,574	2,777,753	776,130	2,001,623
Jan-96	3,329,815	541,950	2,787,865	857,817	1,930,048
Feb-96	3,350,410	543,779	2,806,631	947,492	1,859,139
Mar-96	3,373,127	545,751	2,827,376	1,039,058	1,788,318
Apr-96	3,388,169	547,285	2,840,884	1,124,058	1,716,826
May-96	3,402,598	549,268	2,853,330	1,207,129	1,646,201
Jun-96	3,413,139	551,115	2,862,024	1,286,708	1,575,316
Jul-96	3,426,537	552,899	2,873,638	1,369,264	1,504,374
Aug-96	3,437,561	555,010	2,882,551	1,448,792	1,433,759
Sep-96	3,450,154	556,892	2,893,262	1,530,336	1,362,926
Oct-96	3,463,542	558,913	2,904,629	1,612,443	1,292,186
Nw-96	3,476,185	560,845	2,915,340	1,693,724	1,221,616
Dec-96	3,493,421	562,777	2,930,644	1,779,782	1,150,862
Jan-97	3,508,807	564,665	2,944,142	1,864,483	1,079,659
Feb-97	3,527,090	566,594	2,960,496	1,988,822	971,674
Mar-97	3,545,482	568,526	2,976,956	2,113,269	863,687
Apr-97	3,561,884	570,505	2,991,379	2,235,678	755,701
May-97	3,577,807	572,433	3,005,374	2,357,659	647,715
Jun-97	3,592,269	574,345	3,017,924	2,478,196	539,728
Jul-97	3,608,758	576,382	3,032,376	2,600,635	431,741
Aug-97	3,623,489	578,402	3,045,087	2,721,332	323,755
Sep-97	3,639,575	580,468	3,059,107	2,843,337	215,770
Oct-97	3,655,934	582,620	3,073,314	2,892,232	181,082
Nw-97	3,671,614	584,688	3,086,926	2,940,532	146,394
Dec-97	3,689,867	586,875	3,102,992	2,991,286	111,706
Jan-98	3,706,867	589,059	3,117,808	3,040,790	77,018
Feb-98	3,725,208	591,202	3,134,006	3,119,566	14,440
Mar-98	3,743,791	593,387	3,150,404	3,136,825	13,579
Apr-98	3,761,293	595,576	3,165,717	3,165,658	59
May-98	3,778,587	597,692	3,180,895	3,180,895	0
Jun-98	3,795,824	599,933	3,195,891	3,195,891	0
Jul-98	3,813,760	602,110	3,211,650	3,211,650	0
Aug-98	3,830,502	604,286	3,226,216	3,226,216	0
Sep-98	3,848,308	606,551	3,241,757	3,241,757	0
Oct-98	3,865,790	608,761	3,257,029	3,257,029	0
Nov-98	3,883,326	611,032	3,272,294	3,272,294	0
Dec-98	3,902,217	613,370	3,288,847	3,288,847	0
Jan-99	3,920,011	615,630	3,304,381	3,304,381	0
Feb-99	3,939,145	617,993	3,321,172	3,321,172	0
Mar-99	3,958,305	620,342	3,337,963	3,337,963	0
Apr-99	3,976,874	622,664	3,354,210	3,354,210	0
May-99	3,995,782	625,034	3,370,748	3,370,748	0
Jun-99	4,014,368	627,392	3,386,976	3,386,976	0
Jul-99	4,033,457	629,727	3,403,730	3,403,730	0
Aug-99	4,052,139	632,150	3,419,989	3,419,989	0
Sep-99	4,071,085	634,153	3,436,932	3,436,932	0
Oct-99	4,090,031	636,901	3,453,130	3,453,130	0

Appendix 5.B
Projected Monthly Enrollment

Month	TOTAL ELIGIBLES	EXEMPT ELIGIBLES	TARGET POP.	MANDATORY ENROLLMENT	NOT ENROLLED
Nov-99	4,109,184	639,342	3,469,842	3,469,842	0
Dec-99	4,128,783	641,744	3,487,039	3,487,039	0
Jan-00	4,148,136	644,205	3,503,931	3,503,931	0
Feb-00	4,168,277	646,702	3,521,575	3,521,575	0
Mar-00	4,188,210	649,144	3,539,066	3,539,066	0
Apr-00	4,208,316	651,676	3,556,640	3,556,640	0
May-00	4,228,460	654,182	3,574,278	3,574,278	0
Jun-00	4,248,438	656,687	3,591,751	3,591,751	0
Jul-00	4,268,986	659,244	3,609,742	3,609,742	0
Aug-00	4,288,992	661,775	3,627,217	3,627,217	0
Sep-00	4,309,408	664,316	3,645,092	3,645,092	0

Appendix 5.C
STATE ADJUSTMENTS

3/17/95 10:08

Other Practitioner Services	Chic Services	Laboratory & Radiology Services	Home Health Services	Staffing Services	Abuse Services	ESPT Screening Services	Rural Health Clinic Services	HPD Part-A	HPD Part-B	HPD Co- Insurance & Deductibles	HPD Group Health Plan	HPD Other	Home & Community Based Services	HUO Services For Presidentially Disabled Elderly	Community Supp. Living Arrangement	Personal Care Services	Targeted Case Mgmt. Services	Hospice Benefits	Federally Qualified Health Center	Other Care Services, Other Care
\$7,586,889	\$30,713,029	\$2,824,847	\$124,408,787	\$0	\$0	\$0	\$0	\$114,412	\$86,348,828	\$0	\$0	\$8,342,713	\$3,887,171	\$0	\$0	\$810,215,388	\$1,814,484	\$861,287	\$0	\$22,278,084
\$200,021,036	\$365,889,320	\$10,484,282	\$147,487,182	\$0	\$0	\$4,787,827	\$0	\$8,172	\$6,187,828	\$0	\$0	\$8,450,381	\$12,086,383	\$0	\$0	\$211,520,885	\$2,480,430	\$2,480,430	\$0	\$22,288,088
\$4,174,890	\$102,587,190	\$7,447,725	\$8,510,829	\$5,884,854	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$83,172,897	\$118,842	\$0	\$0	\$2,078,857	\$8,814,088	\$8,814,088	\$0	\$22,288,088
\$124,271,078	\$125,825,854	\$8,788,974	\$8,788,974	\$0	\$0	\$81,285,397	\$0	\$0	\$0	\$0	\$0	\$1,815,888	\$118,842	\$0	\$0	\$2,078,857	\$8,814,088	\$8,814,088	\$0	\$22,288,088
\$1,118,072	\$17,725,684	\$1,725,684	\$141,474,854	\$0	\$0	\$0	\$0	\$32,888	\$24,870,251	\$0	\$0	\$1,815,888	\$23,888	\$0	\$0	\$2,078,857	\$8,814,088	\$8,814,088	\$0	\$22,288,088
\$81,088,072	\$138,827,720	\$1,725,684	\$141,474,854	\$0	\$0	\$863,024	\$0	\$8,172	\$8,187,828	\$0	\$0	\$1,815,888	\$23,888	\$0	\$0	\$2,078,857	\$8,814,088	\$8,814,088	\$0	\$22,288,088
\$1,801,215	\$43,748,210	\$2,380,841	\$2,431,277	\$1,088,521	\$0	\$124,372	\$0	\$0	\$0	\$18,337,862	\$0	\$8,450,381	\$3,887,171	\$0	\$0	\$2,078,857	\$8,814,088	\$8,814,088	\$0	\$22,288,088
\$47,888,472	\$88,478,340	\$2,822,378	\$4,553,578	\$0	\$0	\$37,211,124	\$0	\$0	\$0	\$0	\$0	\$8,450,381	\$47,837	\$0	\$0	\$887,038	\$2,884,032	\$1,380	\$0	\$88,278,748
\$455,828,180	\$882,820,805	\$37,187,582	\$487,280,800	\$7,043,475	\$0	\$104,087,454	\$0	\$183,448	\$123,382,754	\$18,337,862	\$0	\$238,888,088	\$118,842,182	\$0	\$0	\$1,821,841,790	\$87,888,354	\$8,888,357	\$0	\$831,884,188
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$455,828,180	\$882,820,805	\$37,187,582	\$487,280,800	\$7,043,475	\$0	\$104,087,454	\$0	\$183,448	\$123,382,754	\$18,337,862	\$0	\$238,888,088	\$118,842,182	\$0	\$0	\$1,821,841,790	\$87,888,354	\$8,888,357	\$0	\$831,884,188

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FFY 1992-93
Total - Changed

MA PROGRAM

Eligibility Group	Annual Total FP Expenditures	Monthly Average Eligibles	Monthly FP Cost per Eligible	Inpatient Hospital Regular	Inpatient Hospital DSH	Mental Health Fm. Regular	Mental Health Fm. DSH	Nursing Facility Services	ICD-10 Public Providers	ICD-10 Private Providers	Physician Services	Outpatient Hospital Services	Prescribed Drugs	Drug Includes National Agreement	Rebate State Subsidy	Dental Services
SSI - Aged	\$1,940,906,910	148,487	\$963.96	\$602,487,787	\$0	\$102,726,623	\$0	\$279,261,257	\$0	\$0	\$17,364,008	\$37,258,003	\$131,546,127	\$19,142,789	\$0	\$0,000,002
SSI - Blind & Disabled	\$4,372,527,444	238,105	\$1,915.40	\$465,420,124	\$0	\$107,728,277	\$0	\$246,531,433	\$0	\$0	\$11,060,975	\$34,159,408	\$223,546,438	\$54,889,839	\$0	\$13,000,004
SSI - Blind & Disabled	\$1,940,906,910	148,487	\$963.96	\$602,487,787	\$0	\$102,726,623	\$0	\$279,261,257	\$0	\$0	\$17,364,008	\$37,258,003	\$131,546,127	\$19,142,789	\$0	\$0,000,002
AD/DC - Children	\$1,585,113,482	525,178	\$1,188.91	\$368,864,876	\$0	\$8,258,125	\$0	\$4,882,335	\$0	\$0	\$46,317,088	\$133,389,205	\$86,772,877	\$10,882,519	\$0	\$18,073,919
MA-SBI - Aged	\$4,322,527,291	151,482	\$2,877.85	\$142,083,018	\$0	\$232,885,020	\$0	\$1,028,233,036	\$0	\$11,324,029	\$81,182,634	\$18,289,488	\$86,227,814	\$88,287,168	\$0	\$26,128,087
MA-SBI - Blind & Disabled	\$2,857,258,654	81,182	\$2,382.73	\$243,252,075	\$0	\$232,885,020	\$0	\$1,028,233,036	\$0	\$244,884,482	\$118,127,878	\$15,827,884	\$71,187,889	\$88,287,168	\$0	\$1,198,000
MA-ADC - Adult	\$452,961,448	100,331	\$375.88	\$288,288,229	\$0	\$3,331,175	\$0	\$3,331,175	\$0	\$0	\$28,888,184	\$68,011,623	\$11,023,882	\$11,481,889	\$0	\$1,198,000
MA-ADC / MA-HR - Children	\$1,008,421,868	386,480	\$215.90	\$888,075,954	\$0	\$6,888	\$0	\$2,030,002	\$0	\$5,851,878	\$43,046,024	\$82,258,488	\$28,384,144	\$23,781,169	\$0	\$12,581,314
Subtotal: FP Current \$ Excluding DSH	\$17,364,058,368	2,553,113	\$680.78	\$3,718,450,882	\$0	\$882,854,084	\$0	\$3,888,888,728	\$1,488,303,819	\$888,740,403	\$236,810,543	\$821,112,940	\$888,488,885	\$118,814,789	\$0	\$180,000,000
HR - Adults	\$0	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
MA-HR - Adults	\$0	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Subtotal: HR Current \$ (inc. DSH)	\$0	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total: Current \$ Excluding DSH	\$17,364,058,368	2,553,113	\$680.78	\$3,718,450,882	\$0	\$882,854,084	\$0	\$3,888,888,728	\$1,488,303,819	\$888,740,403	\$236,810,543	\$821,112,940	\$888,488,885	\$118,814,789	\$0	\$180,000,000
D & H	\$2,784,477,000			\$0	\$2,180,837,428	\$0	\$883,838,572	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
HR DSH	\$1,401,445,448			\$0	\$1,271,885,878	\$0	\$129,838,572	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
All Other DSH	\$1,383,031,552			\$0	\$819,031,552	\$0	\$448,000,000	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total Current \$ Including DSH	\$20,148,533,366	2,553,113	\$680.78	\$3,718,450,882	\$2,190,837,428	\$882,854,084	\$883,838,572	\$3,888,888,728	\$1,488,303,819	\$888,740,403	\$236,810,543	\$821,112,940	\$888,488,885	\$118,814,789	\$0	\$180,000,000
Adjustments	\$0			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 7	\$838,710,288			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 8	\$0			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 9A	\$81,253,077			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 9B	\$10,884,389			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 9C	\$108,512,062			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 9D	\$2,884,382			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 9E	\$0			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 16A	\$34,855,723			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 16B	\$2,758,388,209			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 10C	\$882,228			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Subtotal: Adjustments	\$2,133,533,293			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Grand Total: MA Program	\$18,015,010,103	2,553,113	\$680.81	\$3,718,450,882	\$2,190,837,428	\$882,854,084	\$883,838,572	\$3,888,888,728	\$1,488,303,819	\$888,740,403	\$236,810,543	\$821,112,940	\$888,488,885	\$118,814,789	\$0	\$180,000,000
Current Administration	\$434,628,737			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Administration Adjustments	\$153,912,847			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 7	\$0			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 8	\$0			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 9A	\$0			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 9B	\$0			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 9C	\$0			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 9D	\$0			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 9E	\$0			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 10A	\$0			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 10B	\$0			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Line 10C	\$0			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Subtotal: Administration Adjustments	\$148,488,819			\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Grand Total: MA Administration	\$584,113,356	0		\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Grand Total: MA Program & Admin.	\$18,599,123,459	2,553,113	\$680.87	\$3,718,450,882	\$2,190,837,428	\$882,854,084	\$883,838,572	\$3,888,888,728	\$1,488,303,819	\$888,740,403	\$236,810,543	\$821,112,940	\$888,488,885	\$118,814,789	\$0	\$180,000,000

[illegible]

DESCRIPTION OF CHANGE: OTHER OMH DSH

FY 1992-93

Total: Changes

	Annual Total FP Expenditures	Monthly Average Eligibles	Monthly FP Cost per Eligible	Inpatient Hospital Regular	Inpatient Hospital DSH	Mental Health Fac. Regular	Mental Health Fac. DSH	Nursing Facility Services	ICF- MR Public Providers	ICF- MR Private Providers	Physician Services	Outpatient Hospital Services	Prescribed Drugs	Drug Related National	Drug Related State	Disputed Services
MA PROGRAM																
Eligible Groups																
BS - Adult	\$0	0		\$0												
BS - Blind & Disabled	\$0															
ACUHR - Children	\$0															
MA-BBI - Adult	\$0															
MA-BBI - Blind & Disabled	\$0															
MA-ADC - Adult	\$0															
MA-ADC / MA-MR - Children	\$0															
Subtotal: FP Current \$ Excluding DSH	\$0	0		\$0												
MR - Adults	\$0															
MA-MR - Adults	\$0															
Subtotal: MR Current \$ (inc. DSH)	\$0	0		\$0												
Total: Current \$ Excluding DSH	\$0	0		\$0												
DSH	\$90,002,838															
MR DSH	\$0															
All Other DSH	\$90,002,838															
Total Current \$ Including DSH	\$90,002,838	0		\$0												
Adjustments																
Line 7	(\$90,002,838)															
Line 8	\$0															
Line 9A	\$0															
Line 9B	\$0															
Line 9C	\$0															
Line 9D	\$0															
Line 9E	\$0															
Line 10A	\$0															
Line 10B	\$0															
Line 10C	\$0															
Subtotal: Adjustments	(\$90,002,838)			\$0												
Grand Total: MA Program	\$0	0		\$0												
MA ADMINISTRATION																
Current Administration																
Administration Adjustments																
Line 7	\$0															
Line 8	\$0															
Line 9A	\$0															
Line 9B	\$0															
Line 9C	\$0															
Line 9D	\$0															
Line 9E	\$0															
Line 10A	\$0															
Line 10B	\$0															
Line 10C	\$0															
Subtotal: Administration Adjustments	\$0															
Grand Total: MA Administration	\$0			\$0												
Grand Total: MA Program & Admin.	\$0			\$0												

DESCRIPTION OF CHANGE: MA FNP-FP
FFY 1992-93
Total - Changes

MA PROGRAM																
Eligibility Groups	Annual Total FP Expenditures	Monthly Average Eligibles	Monthly FP Cost per Eligible	Inpatient Hospital Regular	Inpatient Hospital DSH	Mental Health Fac. Regular	Mental Health Fac. Fc. DSH	Nursing Facility Services	ICF - MR Public Providers	ICF - MR Private Providers	Physician Services	Outpatient Hospital Services	Prescribed Drugs	Drug Related National Agreement	Drug Related State Budget	Dental Services
SSI - Aged	\$0															
SSI - Blind & Disabled	\$0															
ADC - Adult	\$0															
ADCHH - Children	\$0															
MA-SSI - Aged	\$79,500,000			\$0				3		2	\$6,146,888	\$0	\$22,414,882			\$6,087,945
MA-SSI - Blind & Disabled	\$0															
MA-ADC - Adult	\$0															
MA-ADC / MA-HR - Children	\$0															
Subtotal FP Current \$ Including DSH																
HR - Adults	\$0	0		\$0		\$0		3	\$0	2	\$6,086,888	\$0	\$22,414,882	0	\$0	\$6,087,945
MA-HR - Adults	\$0															
Subtotal HR Current \$ (inc. DSH)																
Total: Current \$ Including DSH	\$79,500,000	0		\$0		\$0		3,532	\$0	\$24,588	\$6,146,888	\$0	\$22,414,882	\$0	\$0	\$6,087,945
DSH																
MR DSH	\$0				\$0		\$0									
All Other DSH	\$0															
Total Current \$ Including DSH																
Adjustments	\$79,500,000			\$0		\$0		\$338,532	\$0	1	\$6,146,888	\$0	\$22,414,882	\$0	\$0	\$6,087,945
Line 7																
Line 8																
Line 9A																
Line 9B																
Line 9C																
Line 9D																
Line 9E																
Line 10A																
Line 10B																
Line 10C																
Subtotal Adjustments																
Grand Total: MA Program	\$79,500,000	0		\$0		\$0		\$338,532	\$0	\$24,588	\$6,146,888	\$0	\$22,414,882	\$0	\$0	\$6,087,945
MA ADMINISTRATION																
Current Administration																
Administration Adjustments																
Line 5	\$0															
Line 6	\$0															
Line 6A	\$0															
Line 6B	\$0															
Line 6C	\$0															
Line 6D	\$0															
Line 6E	\$0															
Line 10A	\$0															
Line 10B	\$0															
Line 10C	\$0															
Subtotal Administration Adjustments																
Grand Total: MA Administration	\$0															
Grand Total: MA Program & Admin.	\$0	0														

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Other Professions Services	Other Clinic Services	Laboratory & Radiology Services	Home Health Services	Skilled Nursing	Abortion Services	ESPT Screening Services	Rural Health Clinic Services	HIP Part-A	HIP Part-B	HIP Co- Insurance & Deductible	HIP Group Health Plan	HIP Other	Home & Community Based Services	HMO Services For Functionally Disabled Elderly	Community Res. Living Arrangement	Personal Care Services	Targeted Case Mgmt. Services	Hospice Benefits	Federally Qualified Health Center	Other Care Services, Other Care
\$1,870,128	\$29,108,859	\$2,230,552	\$4,798,648													\$1,842,394	\$913,887	\$44,115		\$1,879,521
\$1,870,128	\$29,108,859	\$2,230,552	\$4,798,648	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$1,842,394	\$913,887	\$44,115	\$0	\$1,879,521
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$1,870,128	\$29,108,859	\$2,230,552	\$4,798,648	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$1,842,394	\$913,887	\$44,115	\$0	\$1,879,521
\$1,870,128	\$29,108,859	\$2,230,552	\$4,798,648	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$1,842,394	\$913,887	\$44,115	\$0	\$1,879,521

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DESCRIPTION OF CHANGE: OSA ADJUSTMENTS
FFY 1992-93
Total - Changes

MA PROGRAM											
Eligibility Groups	Annual Total FP Expenditures	Monthly Average Eligibles	Monthly FP Cost per Eligible	Inpatient Hospital Regular	Inpatient Hospital DSH	Mental Health Fac. Regular	Mental Health Fac. DSH	Nursing Facility Services	KCF- MR Public Providers	KCF- MR Private Providers	Physician Services
Subtotal: FP Current & Enrolling DSH	\$232,439,912	0		\$0		\$57,572,317		\$0	\$13,089,423		\$0
MA-Adults	\$0										
MA-HR - Adults	\$0					\$0					
Subtotal: MR Current & (inc. DSH)	\$0	0		\$0		\$0		\$0	\$0		\$0
Total: Current & Enrolling DSH	\$232,439,912	0		\$0		\$57,572,317		\$0	\$13,089,423		\$0
DSH	\$0										
MR DSH	\$0										
All Other DSH	\$0										
Total Current & Enrolling DSH	\$232,439,912	0		\$0		\$57,572,317		\$0	\$13,089,423		\$0
Adjustments											
Line 7	\$232,439,912										
Line 8	\$0										
Line 9A	\$0										
Line 9B	\$0										
Line 9C	\$0										
Line 9D	\$0										
Line 9E	\$0										
Line 10A	\$0										
Line 10B	\$0										
Line 10C	\$0										
Subtotal: Adjustments	\$232,439,912			\$0		\$0		\$0	\$0		\$0
Grand Total: MA Program	\$0	0		\$0		\$57,572,317		\$0	\$13,089,423		\$0
MA ADMINISTRATION											
Current Administration											
Administration Adjustments											
Line 7	\$0										
Line 8	\$0										
Line 9A	\$0										
Line 9B	\$0										
Line 9C	\$0										
Line 9D	\$0										
Line 9E	\$0										
Line 10A	\$0										
Line 10B	\$0										
Line 10C	\$0										
Subtotal: Administration Adjustments	\$0										
Grand Total: MA Administration	\$0										
Grand Total: MA Program & Admin.	\$0	0									

Other Providers Services	Chic Services	Laboratory & Radiology Services	Home Health Services	Specializations	Abortion	ESPT Screening Services	Rural Health Clinic Services	HP Part-A	HP Part-B	HP Co- Insurance & Deductible	HP Group Health Plan	HP- Other	Home & Community Based Services	MACB Services For Functionally Disabled Elderly	Community Ship Living Arrangement	Personal Care Services	Targeted Case Mgmt. Services	Hospice Benefits	Federally Qualified Health Center	Other Care Services, Other Care
													\$62,045,968			\$6,457,844	\$1,183,101			\$24,600,086
													\$3,354,362			\$728,880	\$65,145			\$28,500,883
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$7187,524	\$288,548	\$0	\$0	\$73,180,752
													\$80,200,300	\$0						
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$80,200,300	\$0	\$0	\$7,187,524	\$1,288,548	\$0	\$0	\$73,180,752
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$80,200,300	\$0	\$0	\$7,187,524	\$288,548	\$0	\$0	\$73,180,752

DESCRIPTION OF CHANGE DBH BY CATEGORY
FFY 1992-93
Total - Changes

MA PROGRAM											
Eligibility Groups	Annual Total FP Expenditures	Monthly Average Eligibles	Monthly FP Cost per Eligible	Inpatient Hospital Regular	Inpatient Hospital DBH	Mental Health Fac. Regular	Mental Health Fac. DBH	Nursing Facility Services	ICF-MR Public Providers	ICF-MR Private Providers	Physician Services
DBH - Adult	\$0	0		\$0		\$0		\$0	\$0	\$0	\$0
DBH - Blind & Disabled	\$0										
ADCHRR - Children	\$0										
MA-SBI - Adult	\$0										
MA-SBI - Blind & Disabled	\$0										
MA-ADC - Adult	\$0										
MA-ADC/MA-HR - Children	\$0										
Subtotal: FP Current & Existing DBH	\$0	0		\$0		\$0		\$0	\$0	\$0	\$0
HR - Adults	\$0										
MA-HR - Adults	\$0										
Subtotal: HR Current & (exc. DBH)	\$0	0		\$0		\$0		\$0	\$0	\$0	\$0
Total: Current & Existing DBH	\$0	0		\$0		\$0		\$0	\$0	\$0	\$0
DBH	\$0										
HR DBH	\$1,401,443,448										
All Other DBH	(81,401,443,448)										
Total Current & Existing DBH	\$0	0		\$0		\$0		\$0	\$0	\$0	\$0
Adjustments											
Line 7	\$0										
Line 8	\$0										
Line 9A	\$0										
Line 9B	\$0										
Line 9C	\$0										
Line 9D	\$0										
Line 9E	\$0										
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Line 9J	\$0										
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Line 10A	\$0										
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Other Practitioner Services	Chic Services	Laboratory & Radiology Services	Home Health Services	Referrals	ESPT Screening Services	Rural Health Clinic Services	HP Part-A	HP Part-B	HP Co- Insurance & Deductible	HP Group Health Plan	HPH	Home & Community Based Services	HCHS Services For Functionally Disabled Elderly	Community Supp. Living Arrangement	Personal Care Services	Temporary Care Nights Services	Homeless Benefits	Federally Qualified Health Center	Other Care Services, Other Care
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90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90
90	90	90	90	90	90	90	90	P	90	90	90	90	90	P	90	90	90	90	90
90	90	90	90	90	90	90	90	P	90	90	90	90	90	P	90	90	90	90	90
90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90

DESCRIPTION OF CHANGE: NEGATIVE RETROACTIVE RATE ADJUSTMENTS
FFY 1992-93
Total Changes

	Annual Total FP Expenditures	Monthly Average Eligible	Monthly FP Cost per Eligible	Inpatient Hospital Regular	Inpatient Hospital DSH	Mental Health Fac. Regular	Mental Health Fac. DSH	Nursing Facility Services	ICF-MR Public Providers	ICF-MR Private Providers	Physician Services	Outpatient Hospital Services	Prescribed Drugs	Drug Reimburse National Agreement	Drug Reimburse State Schedule	Dental Services
MA PROGRAM																
Eligibility Groups																
Sub - Adult & Disabled	(\$19,224,824)			(\$4,418,885)		(\$414,749)		(\$8,912,885)	\$0	(\$875,801)	\$0	(\$834,188)	\$0	\$0		\$0
Sub - Blind & Disabled	(\$1,151,250)			(\$8,775,844)		(\$438,888)		(\$9,174,119)	(\$85,881)	(\$875,801)	\$0	(\$8,623,370)	\$0	\$0		\$0
ADC - Adult	(\$14,145,383)			(\$1,381,586)		\$0		(\$24,818)	\$0	\$0	\$0	(\$3,344,588)	\$0	\$0		\$0
ADC-HR - Children	(\$4,140,522)			(\$1,871,487)		(\$27,883)		(\$7,148,171)	\$0	(\$31,271)	\$0	(\$4,725,618)	\$0	\$0		\$0
MA-SB - Adult	(\$20,778,814)			(\$1,248,487)		(\$842,883)		(\$7,148,171)	\$0	\$0	\$0	(\$291,859)	\$0	\$0		\$0
MA-SB - Blind & Disabled	(\$4,784,809)			(\$2,388,137)		(\$842,883)		(\$10,302,583)	(\$182,817)	(\$841,882)	\$0	(\$1,413,372)	\$0	\$0		\$0
MA-ADC - Adult	(\$10,114,481)			(\$5,004,488)		\$0		(\$82,380)	\$0	\$0	\$0	(\$1,484,437)	\$0	\$0		\$0
MA-ADC / MA-HR - Children						(\$85,083)			\$0	(\$31,271)	\$0	(\$2,312,888)	\$0	\$0		\$0
Subtotal: FP Current \$ Excluding DSH	(\$203,327,158)	0	0	(\$32,708,072)		(\$2,794,885)		(\$88,845,838)	(\$288,788)	(\$1,378,288)	\$0	(\$23,085,788)	\$0	\$0		\$0
MA - Adults	\$0															
MA-HR - Adults	\$0															
Subtotal: HR Current \$ (incl. DSH)	\$0	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total: Current \$ Excluding DSH	(\$203,327,158)	0	0	(\$32,708,072)	\$0	(\$2,794,885)	\$0	(\$88,845,838)	(\$288,788)	(\$1,378,288)	\$0	(\$23,085,788)	\$0	\$0	\$0	\$0
DSH	\$0															
HR DSH	\$0															
All Other DSH	\$0															
Total Current \$ Including DSH	(\$203,327,158)	0	0	(\$32,708,072)	\$0	(\$2,794,885)	\$0	(\$88,845,838)	(\$288,788)	(\$1,378,288)	\$0	(\$23,085,788)	\$0	\$0	\$0	\$0
Adjustments																
Line 7	\$0															
Line 8	\$0															
Line 9A	\$0															
Line 9B	\$0															
Line 9C	\$0															
Line 9D	\$0															
Line 9E	\$0															
Line 10A	\$0															
Line 10B	\$0															
Line 10C	\$0															
Subtotal: Adjustments	(\$203,327,158)															
Grand Total: MA Program	\$0	0	0	(\$32,708,072)	\$0	(\$2,794,885)	\$0	(\$88,845,838)	(\$288,788)	(\$1,378,288)	\$0	(\$23,085,788)	\$0	\$0	\$0	\$0
MA ADMINISTRATION																
Current Administration																
Administration Adjustments																
Line 7	\$0															
Line 8	\$0															
Line 9A	\$0															
Line 9B	\$0															
Line 9C	\$0															
Line 9D	\$0															
Line 9E	\$0															
Line 10A	\$0															
Line 10B	\$0															
Line 10C	\$0															
Subtotal: Administration Adjustments	\$0															
Grand Total: MA Administration	\$0															
Grand Total: MA Program & Admin.	\$0	0	0													

Other Preventive Services	Chic Services	Laboratory & Radiology Services	Home Health Services	Substitutions	Abortion	ESPTOT Screening Services	Rural Health Clinic Services	HSP Part-A	HSP Part-B	HSP Co- Insurance & Deductible	HSP Group Health Plan	HSP Other	Home & Community Based Services	HSP Services For Physically Disabled Elderly	Community App. Living Arrangement	Personal Care Services	Targeted Case Mgmt. Services	Hospice Benefits	Federally Qualified Health Center	Other Case Services, Other Care
00	(358,880)	00	(1,802,117)	00	00	00	00	00	00	00	00	(328,884)	(85,624)	00	00	(33,784,178)	(858,101)	(8,271)	00	(828,881)
00	(88,751,212)	00	(82,250,888)	00	00	(328,551)	00	00	00	00	00	(323,478)	(178,627)	00	00	(51,883,487)	(1,188,862)	(82,791)	00	(82,888,528)
00	(81,811,841)	00	(889,544)	(882,887)	00	00	00	00	00	00	00	(328,128)	00	00	00	(812,823)	(882,288)	(8,132)	00	(81,888,488)
00	(82,282,818)	00	(1134,428)	00	00	(828,562)	00	00	00	00	00	(818,577)	(818)	00	00	(88,838)	(328,137)	(82,732)	00	(81,818,787)
00	(319,780)	00	(82,183,888)	00	00	00	00	00	00	00	00	(828,787)	(828)	00	00	(83,528,884)	(88,118)	(82,732)	00	(828,478)
00	(82,577,855)	00	(8848,888)	00	00	(82,848)	00	00	00	00	00	(84,381)	(88,188)	00	00	(888,781)	(813,882)	(81,324)	00	(8843,788)
00	(8807,848)	00	(837,885)	(811,884)	00	(858)	00	00	00	00	00	(828,882)	00	00	00	(888,872)	(813,882)	(8,107)	00	(828,788)
00	(81,284,284)	00	(888,822)	00	00	(818,388)	00	00	00	00	00	(830,232)	(878)	00	00	(85,453)	(888,732)	(82)	00	(81,188,214)
00	(818,482,458)	00	(87,807,451)	(873,781)	00	(848,807)	00	00	00	00	00	(888,188)	(818,342)	00	00	(88,888,328)	(81,847,281)	(87,882)	00	(88,888,388)

00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00
00	(818,482,458)	00	(87,807,451)	(873,781)	00	(848,807)	00	00	00	00	00	(888,188)	(818,342)	00	00	(88,888,328)	(81,847,281)	(87,882)	00	(88,888,388)

00	(818,482,458)	00	(87,807,451)	(873,781)	00	(848,807)	00	00	00	00	00	(888,188)	(818,342)	00	00	(88,888,328)	(81,847,281)	(87,882)	00	(88,888,388)
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00	00	U	U	00	00	00	U	U	00	00	00	00	00	00	00	00	00	00	00	00
00	(818,482,458)	U	(87,807,451)	(873,781)	00	(848,807)	U	U	00	00	00	(888,188)	(818,342)	00	00	(88,888,328)	(81,847,281)	(87,882)	00	(88,888,388)

FFY 1993-94
Total

MA PROGRAM
Eligibility Groups

S81 - Aged	\$2,120,200,218	172,718	\$1,022.97	\$514,237,373	\$68,388,238	\$286,873,904	\$0	\$0	\$24,438,371	\$38,188,185	\$146,588,527	(\$22,177,397)	\$0	\$7,583,234
S81 - Blind & Disabled	\$4,891,000,581	368,718	\$1,048.50	\$1,151,880,335	\$80,373,268	\$279,883,748	\$0	\$0	\$89,949,377	\$128,789,187	\$146,588,527	(\$13,719,381)	\$0	\$7,583,234
ADC - Adult	\$1,000,910,804	403,780	\$238.58	\$438,284,518	\$0	\$802,405	\$0	\$0	\$89,949,377	\$128,789,187	\$146,588,527	(\$13,719,381)	\$0	\$7,583,234
ADC-HR - Children	\$1,611,251,863	658,558	\$140.37	\$658,883,533	\$5,737,348	\$4,104,122	\$0	\$0	\$89,949,377	\$128,789,187	\$146,588,527	(\$13,719,381)	\$0	\$7,583,234
MA-S81 - Aged	\$4,577,590,646	153,652	\$2,478.42	\$112,738,287	\$188,346,088	\$3,238,354,468	\$0	\$0	\$22,631,087	\$21,858,538	\$73,532,231	(\$18,531,478)	\$0	\$4,577,590,646
MA-S81 - Blind & Disabled	\$2,784,387,070	86,465	\$2,883.13	\$274,820,484	\$188,346,088	\$452,388,435	\$0	\$0	\$14,270,477	\$64,894,912	\$163,000,257	(\$14,211,453)	\$0	\$2,784,387,070
MA-ADC - Adult	\$1,000,910,804	403,780	\$238.58	\$438,284,518	\$0	\$802,405	\$0	\$0	\$89,949,377	\$128,789,187	\$146,588,527	(\$13,719,381)	\$0	\$7,583,234
MA-ADC - MA-HR - Children	\$1,174,544,658	413,237	\$2,823.32	\$702,832,868	\$0	\$2,784,387,070	\$0	\$0	\$84,411,003	\$86,183,008	\$27,878,137	(\$4,218,608)	\$0	\$1,174,544,658

Subtotal: FFY Current \$ Excluding DSH

HR - Adults	\$18,811,015,418	2,882,311	\$6,542.24	\$4,181,013,832	\$573,794,824	\$4,274,828,880	\$1,374,887,088	\$0	\$327,534,545	\$888,137,024	\$888,088,351	(\$131,861,352)	\$0	\$112,169,428
MA-HR - Adults	\$0	0	\$0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Subtotal: HR Current \$ (inc. DSH)	\$18,811,015,418	2,882,311	\$6,542.24	\$4,181,013,832	\$573,794,824	\$4,274,828,880	\$1,374,887,088	\$0	\$327,534,545	\$888,137,024	\$888,088,351	(\$131,861,352)	\$0	\$112,169,428
Total: Current \$ Excluding DSH	\$18,811,015,418	2,882,311	\$6,542.24	\$4,181,013,832	\$573,794,824	\$4,274,828,880	\$1,374,887,088	\$0	\$327,534,545	\$888,137,024	\$888,088,351	(\$131,861,352)	\$0	\$112,169,428

DSH

HR DSH	\$2,411,801,704	0	\$0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
All Other DSH	\$2,411,801,704	0	\$0.00	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total Current \$ Including DSH	\$21,222,617,120	2,882,311	\$6,542.24	\$4,181,013,832	\$573,794,824	\$4,274,828,880	\$1,374,887,088	\$0	\$327,534,545	\$888,137,024	\$888,088,351	(\$131,861,352)	\$0	\$112,169,428

Adjustments

Line 7	\$854,194,088													
Line 8	\$28,728,728													
Line 9A	(\$85,014,293)													
Line 9B	(\$14,619,817)													
Line 9C	(\$135,612,840)													
Line 9D	(\$2,886,759)													
Line 9E	\$0													
Line 10A	(\$2,610,850)													
Line 10B	(\$128,504,764)													
Line 10C	(\$334,182,528)													
Subtotal: Adjustments	\$259,191,418													
Grand Total: MA Program	\$21,472,718,538	2,882,311	\$6,542.24	\$4,181,013,832	\$573,794,824	\$4,274,828,880	\$1,374,887,088	\$0	\$327,534,545	\$888,137,024	\$888,088,351	(\$131,861,352)	\$0	\$112,169,428

MA ADMINISTRATION

Current Administration	\$487,508,820													
Administration Adjustments	\$205,638,458													
Line 7	\$0													
Line 8	\$0													
Line 9A	\$0													
Line 9B	\$0													
Line 9C	\$0													
Line 9D	\$0													
Line 9E	\$0													
Line 10A	\$0													
Line 10B	(\$37,993,502)													
Line 10C	\$0													
Subtotal: Administration Adjustments	\$187,845,954													
Grand Total: MA Administration	\$675,354,774													
Grand Total: MA Program & Admin.	\$22,147,718,538	2,882,311	\$6,542.24	\$4,181,013,832	\$573,794,824	\$4,274,828,880	\$1,374,887,088	\$0	\$327,534,545	\$888,137,024	\$888,088,351	(\$131,861,352)	\$0	\$112,169,428

9/17/85 10:03

Other Providers Services	Clinic Services	Laboratory & Radiology Services	Home Health Services	Surveillance	Abortion	EBPOT Screening Services	Rural Health Clinic Services	HIP Part-A	HIP Part-B	HIP Co- Insurance & Deductible	HIP Group Health Plan	HIP-Other	Home & Community Based Services	HACB Services For Presidentially Disabled Elderly	Community Rept. Living Arrangement	Personal Care Services	Targeted Case Mgmt. Services	Hospice Benefits	Federally Qualified Health Center	Other Care Services, Other Care
\$4,305,223	\$28,022,186	\$3,845,037	\$136,458,580	\$0	\$0	\$0	\$0	\$182,123	\$105,889,361	\$0	\$0	\$10,874,120	\$0	\$0	\$0	\$0	\$2,388,089	\$0	PPPPPPPP	\$23,844,882
\$137,568,382	\$413,873,174	\$11,887,173	\$183,564,382	\$0	\$0	\$0	\$0	\$13,723	\$7,583,342	\$0	\$0	\$12,188,488	\$28,628,828	\$0	\$0	\$0	\$48,888,055	\$2,771,525	\$0	\$23,844,882
\$4,445,885	\$85,834,174	\$7,233,227	\$7,820,714	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$185,880,725	\$284,250,520	\$0	\$0	\$0	\$48,888,055	\$2,771,525	\$0	\$23,844,882
\$18,088,918	\$11,188,798	\$4,184,289	\$10,244,374	\$0	\$0	\$105,871,344	\$0	\$0	\$0	\$0	\$0	\$284,828,873	\$314,808	\$0	\$0	\$0	\$2,388,089	\$182,744	\$0	\$23,844,882
\$18,088,918	\$11,188,798	\$4,184,289	\$10,244,374	\$0	\$0	\$105,871,344	\$0	\$0	\$0	\$0	\$0	\$284,828,873	\$314,808	\$0	\$0	\$0	\$2,388,089	\$182,744	\$0	\$23,844,882
\$20,848,247	\$147,428,445	\$3,271,852	\$12,238,544	\$0	\$0	\$0	\$0	\$54,882	\$35,254,188	\$0	\$0	\$11,238,851	\$82,821	\$0	\$0	\$0	\$48,888,055	\$2,388,089	\$0	\$23,844,882
\$1,828,807	\$42,318,027	\$2,881,780	\$3,210,053	\$1,381,188	\$0	\$248,288	\$0	\$13,723	\$7,583,342	\$17,757,878	\$0	\$11,888,247	\$10,224,878	\$0	\$0	\$0	\$48,888,055	\$2,388,089	\$0	\$23,844,882
\$24,834,638	\$97,182,528	\$2,855,634	\$8,518,425	\$0	\$0	\$84,822,888	\$0	\$0	\$0	\$0	\$0	\$18,583,142	\$728,842	\$0	\$0	\$0	\$48,888,055	\$2,388,089	\$0	\$23,844,882
\$353,350,805	\$820,704,355	\$40,118,579	\$578,484,200	\$8,207,875	\$0	\$182,343,888	\$0	\$274,482	\$151,270,830	\$17,757,878	\$0	\$434,841,214	\$314,808,588	\$0	\$0	\$0	\$72,484,888	\$8,488,348	\$0	\$734,386,423
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
\$353,350,805	\$820,704,355	\$40,118,579	\$578,484,200	\$8,207,875	\$0	\$182,343,888	\$0	\$274,482	\$151,270,830	\$17,757,878	\$0	\$434,841,214	\$314,808,588	\$0	\$0	\$0	\$72,484,888	\$8,488,348	\$0	\$734,386,423

EXPENSE YOURSELF

Other Procedures	Chic Services	Laboratory & Radiology Services	Home Health Services	Skilled Nursing Services	Rural Health Clinic Services	HIP Part-A	HIP Part-B	HIP Co- Insurance & Deductible	HIP Group Health Plan	HIP- Other	Home & Community Based Services	HACB Services For Previously Disabled Elderly	Community Shop, Laundry Arrangement	Personal Care Services	Targeted Case Mgmt. Services	Hospice Benefits	Federally Qualified Health Center	Other Care Services, Other Care	
(52,048,004) (534,874,042) (51,088,007) (54,741,842) (510,734,449) (5473,881) (55,584,117) (545,341,003)	(51,013,879) (514,854,125) (53,467,852) (54,016,860) (54,741,842) (51,329,868) (52,429,949) (54,865,256)	\$2,012,436 \$2,012,436 \$2,012,436 \$2,012,436 \$2,012,436 \$2,012,436 \$2,012,436 \$2,012,436	(51,503,586) (51,984,620) (52,467,852) (54,016,860) (54,741,842) (51,329,868) (52,429,949) (54,865,256)	\$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	\$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	\$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	\$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	\$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	\$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	(53,345,365) (53,467,852) (53,590,339) (54,123,879) (54,246,366) (54,368,853) (54,491,339) (54,613,826)	\$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	(515,770) \$74,770,833 (516,112) (516,454) (516,796) (517,138) (517,480) (517,822)	\$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	(55,315,289) \$4,042,284 (529,139) (515,194) (54,861,765) \$1,444,857 (57,281) (59,886) (54,867,542)	\$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	(54,862) \$1,053,115 (55,769) (515,847) (54,861,765) \$1,075,834 \$5,873 (54,879) \$2,126,166	(51,861) (52,468) (55,769) \$0 (515,770) \$54,868 (516,112) (516,454) \$52,410	\$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0	(5148,352) \$10,877,136 (538,585) (538,585) (538,585) \$11,703,539 \$15,193 (5377,389) \$24,877,136
(505,341,003)	(54,865,256)	\$2,012,436	(554,016) (555,313)	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	(53,468,536) \$0	\$109,863,524 \$0	\$0 \$0	\$0 \$0	(54,867,542) \$0	\$2,126,166 \$0	\$52,410 \$0	\$0 \$0	\$0 \$0	
(505,341,003)	(54,865,256)	\$2,012,436	(554,016) (555,313)	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	(53,468,536) \$0	\$109,863,524 \$0	\$0 \$0	\$0 \$0	(54,867,542) \$0	\$2,126,166 \$0	\$52,410 \$0	\$0 \$0	\$0 \$0	
(505,341,003)	(54,865,256)	\$2,012,436	(554,016) (555,313)	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	(53,468,536) \$0	\$109,863,524 \$0	\$0 \$0	\$0 \$0	(54,867,542) \$0	\$2,126,166 \$0	\$52,410 \$0	\$0 \$0	\$0 \$0	
(505,341,003)	(54,865,256)	\$2,012,436	(554,016) (555,313)	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	(53,468,536) \$0	\$109,863,524 \$0	\$0 \$0	\$0 \$0	(54,867,542) \$0	\$2,126,166 \$0	\$52,410 \$0	\$0 \$0	\$0 \$0	
(505,341,003)	(54,865,256)	\$2,012,436	(554,016) (555,313)	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	(53,468,536) \$0	\$109,863,524 \$0	\$0 \$0	\$0 \$0	(54,867,542) \$0	\$2,126,166 \$0	\$52,410 \$0	\$0 \$0	\$0 \$0	
(505,341,003)	(54,865,256)	\$2,012,436	(554,016) (555,313)	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	(53,468,536) \$0	\$109,863,524 \$0	\$0 \$0	\$0 \$0	(54,867,542) \$0	\$2,126,166 \$0	\$52,410 \$0	\$0 \$0	\$0 \$0	
(505,341,003)	(54,865,256)	\$2,012,436	(554,016) (555,313)	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	(53,468,536) \$0	\$109,863,524 \$0	\$0 \$0	\$0 \$0	(54,867,542) \$0	\$2,126,166 \$0	\$52,410 \$0	\$0 \$0	\$0 \$0	
(505,341,003)	(54,865,256)	\$2,012,436	(554,016) (555,313)	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	(53,468,536) \$0	\$109,863,524 \$0	\$0 \$0	\$0 \$0	(54,867,542) \$0	\$2,126,166 \$0	\$52,410 \$0	\$0 \$0	\$0 \$0	
(505,341,003)	(54,865,256)	\$2,012,436	(554,016) (555,313)	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	(53,468,536) \$0	\$109,863,524 \$0	\$0 \$0	\$0 \$0	(54,867,542) \$0	\$2,126,166 \$0	\$52,410 \$0	\$0 \$0	\$0 \$0	
(505,341,003)	(54,865,256)	\$2,012,436	(554,016) (555,313)	\$0 \$0	\$														

DESCRIPTION OF CHANGE: MA FNP-FP
FFY 1993-94
Total - Changes

MA PROGRAM	Annual Total FP Expenditures	Monthly Average per Eligible	Monthly FP Cost per Eligible	Inpatient Hospital Regular	Inpatient Hospital DSH	Mental Health Fac. Regular	Mental Health Fac. DSH	Nursing Facility Services	ICF-MR Public Providers	ICF-MR Private Providers	Physician Services	Outpatient Hospital Services	Prescribed Drugs	Drug Include National Agreement	Drug Exclude State Statute	David
Eligibility Groups																
SSI - Blind	30															
SSI - Blind & Disabled	30															
ADC - Adult	30															
ADC/HR - Children	30															
MA-SBI - Aged	30															
MA-SBI - Blind & Disabled	30															
MA-ADC - Adult	30															
MA-ADC / MA-HR - Children	30															
Subtotal: FP Current \$ Excluding DSH	\$78,500,000	0		30		30		\$400,837	30	\$27,884	\$6,873,011	30	\$23,897,889	30		a
HR - Adults	30															
MA-HR - Adults	30															
Subtotal: HR Current \$ (inc. DSH)	30	0		30		30		30	30	30	30	30	30	30	30	30
Total: Current \$ Excluding DSH	\$78,500,000	0		30		30		\$400,837	30	\$27,884	\$6,873,011	30	\$23,897,889	30	30	30
DSH	30															
HR DSH	30															
All Other DSH	30															
Total Current \$ Including DSH	\$78,500,000	0		30	30	30	30	\$400,837	30	\$27,884	\$6,873,011	30	\$23,897,889	30	30	a
Adjustments																
Line 7	(\$78,500,000)															
Line 8	30															
Line 9A	30															
Line 9B	30															
Line 9C	30															
Line 9D	30															
Line 9E	30															
Line 10A	30															
Line 10B	30															
Line 10C	30															
Subtotal: Adjustments	(\$78,500,000)			30	30	30	30	\$400,837	30	\$27,884	\$6,873,011	30	\$23,897,889	30	30	30
Grand Total: MA Program	30	0		30	30	30	30	\$400,837	30	\$27,884	\$6,873,011	30	\$23,897,889	30	30	30
MA ADMINISTRATION																
Current Administration																
Administration Adjustments																
Line 7	30															
Line 8	30															
Line 9A	30															
Line 9B	30															
Line 9C	30															
Line 9D	30															
Line 9E	30															
Line 10A	30															
Line 10B	30															
Line 10C	30															
Subtotal: Administration Adjustments	30															
Grand Total: MA Administration	30															
Grand Total: MA Program & Admin.	30	0														

Other Practitioner Services	Clinic Services	Laboratory & Radiology Services	Home Health Services	Sterilizations	Abortions	ESGOT Screening Services	Rural Health Clinic Services	HIP Part-A	HIP Part-B	HIP Co- Insurance & Deductible	HIP Group Health Plan	Hip- Other	Home & Community Based Services	HACC Services For Functionally Disabled Elderly	Community Supp. Living Arrangement	Personal Care Service	Targeted Case Mgmt. Services	Hospice Benefits	Federally Qualified Health Center	Other Care Services, Other Care
\$1,835,118	\$28,587,387	\$2,012,438	\$878,411	1				\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$1,882,330	\$808,144	\$80,244	\$0	\$3,287,888
\$1,835,118	\$28,587,387	\$2,012,438	\$878,411	1	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$1,882,330	\$808,144	\$80,244	\$0	\$3,287,888
\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$82,330	\$808,144	\$80,244	\$0	\$0
\$1,835,118	\$28,587,387	\$2,012,438	\$8,578,411	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$82,330	\$808,144	\$80,244	\$0	\$3,287,888
\$1,835,118	\$28,587,387	\$2,012,438	\$8,578,411	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$82,330	\$808,144	\$80,244	\$0	\$3,287,888

DESCRIPTION OF CHANGE: OGA ADJUSTMENTS
FFY 1993-94
Total - Changes

MA PROGRAM	Annual Total FP Expenditures	Monthly Average Eligible	Monthly FP Cost per Eligible	Inpatient Hospital Regular	Inpatient Hospital DSH	Mental Health Pw. Regular	Mental Health Pw. DSH	Mental Health Fac. DSH	Outpatient Facility Services	ICF-MR Public Providers	ICF-MR Private Providers	Physician Services	Outpatient Hospital Services	Prescribed Drugs	Drug Reimburse National Agreement	Drug Reimburse State Schedule	Dental Services
Eligibility Groups																	
SSI - Aged	\$8,833,210					\$8,833,210											
SSI - Blind & Disabled	\$11,796,178					\$8,833,210											
ADC - Adult	\$0					\$0											
ADCW - Children	\$47,392					\$47,392											
MA-SBI - Blind & Disabled	\$21,383,014					\$21,383,014											
MA-SBI - Blind & Disabled	\$21,383,014					\$21,383,014											
MA-ADC - Adult	\$10,498					\$10,498											
MA-ADC / MA-HR - Children	\$58,870					\$58,870											
Subtotal: FP Current \$ Excluding DSH	\$228,465,295	0	0	0	0	\$82,758,709											
HR - Adults	\$0					\$0											
MA-HR - Adults	\$0					\$0											
Subtotal: HR Current \$ (inc. DSH)	\$0	0	0	0	0	\$0											
Total: Current \$ Excluding DSH	\$228,465,295	0	0	0	0	\$82,758,709											
DSH	\$0					\$0											
HR DSH	\$0					\$0											
All Other DSH	\$0					\$0											
Total Current \$ Including DSH	\$228,465,295	0	0	0	0	\$82,758,709											
Adjustments																	
Line 7	(\$228,465,295)																
Line 8	\$0																
Line 9A	\$0																
Line 9B	\$0																
Line 9C	\$0																
Line 9D	\$0																
Line 9E	\$0																
Line 10A	\$0																
Line 10B	\$0																
Line 10C	\$0																
Subtotal: Adjustments	(228,465,295)																
Grand Total: MA Program	\$0	0	0	0	0	\$82,758,709											
MA ADMINISTRATION																	
Current Administration																	
Administration Adjustments																	
Line 7	\$0																
Line 8	\$0																
Line 9A	\$0																
Line 9B	\$0																
Line 9C	\$0																
Line 9D	\$0																
Line 9E	\$0																
Line 10A	\$0																
Line 10B	\$0																
Line 10C	\$0																
Subtotal: Administration Adjustments	\$0																
Grand Total: MA Administration	\$0																
Grand Total: MA Program & Admin.	\$0	0	0	0	0	\$82,758,709											

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[illegible]

DESCRIPTION OF CHANGE: NEGATIVE RETROACTIVE RATE ADJUSTMENTS
FFY 1993, MA
Total Changes

Eligibility Group	Annual Total FP Expenditures	Monthly Average Eligibles	Monthly FP Cost per Eligible	Resident Hospital Regular	Resident Hospital DSH	Medicaid Health Fac. Regular	Medicaid Health Fac. Fc. DSH	Nursing Facility Services	ICF-IIR Public Providers	ICF-IIR Private Providers	Physician Services	Outpatient Hospital Services	Freestanding Clinics	Drug Reimbursement National Agreement	Drug Reimbursement State Slider	Dental Services
MA PROGRAM																
Subtotal: MA Program	(\$21,264,262)			(\$7,014,783)		(\$654,039)		(\$5,000,434)	\$0	\$0	\$0	\$0	(\$666,549)	\$0	\$0	\$0
SSI - Blind & Disabled	(\$14,023,429)			(\$4,710,370)		(\$600,219)		(\$3,373,068)	(\$1,789)	(\$1,310,210)	\$0	\$0	(\$9,263,748)	\$0	\$0	\$0
ADCA - Adult	(\$14,003,539)			(\$4,698,529)		\$0		(\$11,273)	\$0	\$0	\$0	\$0	(\$1,843,009)	\$0	\$0	\$0
ADCA - Children	(\$38,750,451)			(\$12,883,139)		(\$68,870)		(\$78,794)	\$0	(\$43,222)	\$0	\$0	(\$2,360,072)	\$0	\$0	\$0
MA-SBI - Blind & Disabled	(\$78,150,200)			(\$25,716,739)		(\$1,942,878)		(\$2,932,370)	\$0	\$0	\$0	\$0	(\$332,819)	\$0	\$0	\$0
MA-SBI - Adult	(\$38,368,367)			(\$12,750,365)		(\$1,942,878)		(\$2,932,370)	(\$81,774)	(\$686,437)	\$0	\$0	(\$643,782)	\$0	\$0	\$0
MA-ADC - Adult	(\$7,748,809)			(\$2,581,405)		\$0		(\$68,367)	\$0	\$0	\$0	\$0	(\$2,152,182)	\$0	\$0	\$0
MA-ADC - MA-HR - Children	(\$22,785,894)			(\$7,593,442)		(\$1,894)		(\$1,894)	\$0	(\$21,811)	\$0	\$0	(\$1,354,139)	\$0	\$0	\$0
Subtotal: PP Current & Excluding DSH	(\$308,563,004)	0	0	(\$87,187,349)	\$0	(\$5,887,589)	\$0	(\$82,073,812)	(\$83,549)	(\$2,181,089)	\$0	\$0	(\$13,794,077)	\$0	\$0	\$0
MA-HR - Adults	\$0															
MA-HR - Children	\$0															
Subtotal: MA Program & Excluding DSH	\$0	0	0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Total: Current & Excluding DSH	(\$308,563,004)	0	0	(\$87,187,349)	\$0	(\$5,887,589)	\$0	(\$82,073,812)	(\$83,549)	(\$2,181,089)	\$0	\$0	(\$13,794,077)	\$0	\$0	\$0
D & H DSH	\$0				\$0		\$0									
All Other DSH	\$0															
Total Current & Including DSH	(\$308,563,004)	0	0	(\$87,187,349)	\$0	(\$5,887,589)	\$0	(\$82,073,812)	(\$83,549)	(\$2,181,089)	\$0	\$0	(\$13,794,077)	\$0	\$0	\$0
Adjustments																
Line 7	\$0															
Line 8	\$0															
Line 9A	\$0															
Line 9B	\$0															
Line 9C	\$0															
Line 9D	\$0															
Line 9E	\$0															
Line 10A	\$0															
Line 10B	\$0															
Line 10C	\$0															
Subtotal: Adjustments	\$308,563,004															
Grand Total: MA Program	\$308,563,004	0	0	(\$87,187,349)	\$0	(\$5,887,589)	\$0	(\$82,073,812)	(\$83,549)	(\$2,181,089)	\$0	\$0	(\$13,794,077)	\$0	\$0	\$0
MA ADMINISTRATION																
Current Administration																
Administration Adjustments																
Line 7	\$0															
Line 8	\$0															
Line 9A	\$0															
Line 9B	\$0															
Line 9C	\$0															
Line 9D	\$0															
Line 9E	\$0															
Line 10A	\$0															
Line 10B	\$0															
Line 10C	\$0															
Subtotal: Administration Adjustments	\$0															
Grand Total: MA Administration	\$0															
Grand Total: MA Program & Admin.	\$0	0	0													

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Other Practitioner Services	Clinic Services	Laboratory & Radiology Services	Home Health Services	Skilled Nursing Services	Abortion Services	ES/PT/OT Screening Services	Rural Health Clinic Services	HP Part-A	HP Part-B	HP Co- Insurance & Deductible	HP Group Health Plan	High-Other	Home & Community Based Services	HCSB Services For Functionally Disabled Elderly	Community Supp. Living Arrangement	Personal Care Services	Targeted Case Mgmt. Services	Hospice Benefits	Family Qualified Health Center	Other Case Services, Other Care
(52,048,000)	(51,812,879)	00	(51,802,588)	00	00	00	00	00	00	00	00	(53,355)	(515,778)	00	00	(55,316,289)	(54,852)	(51,851)	00	(514,253)
(538,814,082)	(514,854,120)	00	(51,802,588)	00	00	(517,048)	00	00	00	00	00	(584,888)	(5452,185)	00	00	(52,346,064)	(58,538)	(57,848)	00	(51,871,808)
(51,086,807)	(53,887,552)	00	(52,273)	00	00	00	00	00	00	00	00	(51,326,168)	(5452,185)	00	00	(52,346,064)	(58,538)	(57,848)	00	(51,871,808)
(518,774,881)	(54,718,880)	00	(511,251)	00	00	(518,412)	00	00	00	00	00	(51,326,168)	(5452,185)	00	00	(52,346,064)	(58,538)	(57,848)	00	(51,871,808)
(54,741,842)	(5338,844)	00	(51,700,278)	00	00	00	00	00	00	00	00	(51,326,168)	(5452,185)	00	00	(52,346,064)	(58,538)	(57,848)	00	(51,871,808)
(512,588,578)	(55,328,332)	00	(5783,287)	00	00	(51,752)	00	00	00	00	00	(51,326,168)	(5452,185)	00	00	(52,346,064)	(58,538)	(57,848)	00	(51,871,808)
(5475,861)	(51,328,888)	00	(534,888)	00	00	(545)	00	00	00	00	00	(51,326,168)	(5452,185)	00	00	(52,346,064)	(58,538)	(57,848)	00	(51,871,808)
(58,964,147)	(52,428,848)	00	(570,785)	00	00	(518,287)	00	00	00	00	00	(5145,182)	(5288)	00	00	(57,287)	(51,279)	(578)	00	(51,871,808)
(587,176,121)	(533,382,823)	00	(58,288,428)	(555,313)	00	(538,873)	00	00	00	00	00	(53,488,538)	(5515,551)	00	00	(514,234,888)	(5148,532)	(528,532)	00	(53,116,848)
00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00	00
(587,176,121)	(533,382,823)	00	(58,288,428)	(555,313)	00	(538,873)	00	00	00	00	00	(53,488,538)	(5515,551)	00	00	(514,234,888)	(5148,532)	(528,532)	00	(53,116,848)
(587,176,121)	(533,382,823)	00	(58,288,428)	(555,313)	00	(538,873)	00	00	00	00	00	(53,488,538)	(5515,551)	00	00	(514,234,888)	(5148,532)	(528,532)	00	(53,116,848)

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Printed on 03/17/95

DESCRIPTION OF CHANGE: OMH DSH
FFY 1993-94
Total - Changes

MA PROGRAM	Annual Total FF Expenditure	Monthly Average Eligible	Monthly FF Cost per Eligible	Inpatient Hospital Regular	Inpatient Hospital DSH	Mental Health Fac. Regular	Mental Health Fac. DSH	Nursing Facility Services	ICF - MR Public Providers	ICF - MR Private Providers	Physician Services	Outpatient Hospital Services	Prescribed Drugs	Drug Related National Agreement	Drug Related State Subsidy	Disadv Services
Eligibility Groups																
SSI - Aged	90															
SSI - Blind & Disabled	90															
AUC - Adult	90															
ADCHH - Children	90															
MA-SSI - Aged	90															
MA-SSI - Blind & Disabled	90															
MA-DC - Adult	90															
MA-DC - Blind & Disabled	90															
MA-DC - Youth	90															
MA-DC / MA-HR - Children	90															
Subtotal: FF Current \$ Excluding DSH	90	0		90		0										
HR - Adults	90															
MA-HR - Adults	90															
Subtotal: HR Current \$ (inc. DSH)	90					90	90									
Total: Current \$ Excluding DSH	90	0		90	90	90										
DSH	\$420,262,296				90		\$420,262,296									
HR DSH	90															
All Other DSH	\$420,262,296						\$420,262,296									
Total Current \$ Including DSH	\$420,262,296	0		0	90	0	\$420,262,296									
Adjustments																
Line 7	(9420,262,296)															
Line 8	90															
Line 9A	90															
Line 9B	90															
Line 9C	90															
Line 9D	90															
Line 9E	90															
Line 10A	90															
Line 10B	90															
Line 10C	90															
Subtotal: Adjustments	(9420,262,296)															
Grand Total: MA Program	90	0		90	90	90	\$420,262,296									
MA ADMINISTRATION																
Current Administration																
Administration Adjustments																
Line 7	90															
Line 8	90															
Line 9A	90															
Line 9B	90															
Line 9C	90															
Line 9D	90															
Line 9E	90															
Line 10A	90															
Line 10B	90															
Line 10C	90															
Subtotal: Administration Adjustments	90															
Grand Total: MA Administration	90															
Grand Total: MA Program & Admin.	90	0														

Other Procedures	Laboratory & Radiology Services	Home Health Services	Sterilizations	Abortions	ESTD Screening Services	Rural Health Clinic Services	HIP Part-B	HIP Part-A	HIP Group Health Plan	HIP-Other Community Based Services	Home & Community Based Services	MCHS Services For Physically Disabled Elderly	Supp. Living Arrangement	Personal Care Services	Targeted Case Mgmt. Services	Hospice Benefits	Federally Qualified Health Centers	Other Care
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Appendix 5.D
ALLOCATION PERCENTAGE

Exempt Expenditures and Exempt Eligibles Summary Table

	EXEMPT POPULATION ALL SERVICES EXPENDITURES	INCLUDED POPULATION NON-COVERED SERVICES EXPENDITURES	INCLUDED POPULATION COVERED SERVICES EXPENDITURES
SSI Aged	\$1,903,099,410	\$67,367,746	\$156,556,708
SSI Blind & Disabled	\$1,980,936,222	\$235,333,307	\$2,011,288,826
ADC Adults	\$5,118,282	\$1,571,885	\$911,273,693
ADC/HR Children	\$84,567,504	\$75,169,718	\$1,327,792,144
MA SSI Aged	\$4,657,057,759	\$12,257,401	\$61,818,874
MA SSI Blind & Disabled	\$2,211,865,541	\$16,146,105	\$403,662,633
MA ADC Adults	\$53,666,595	\$215,585	\$353,713,199
MA-ADC/MA HR Children	\$71,541,113	\$7,602,996	\$605,030,605
HR Adults	\$21,452,592	\$3,910,592	\$458,237,731
MA HR Adults	\$3,778,356	\$377,150	\$49,896,748
Total	\$10,973,083,374	\$419,952,485	\$6,339,271,161
			\$17,732,307,020

	EXEMPT POPULATION ELIGIBLE MONTHS	INCLUDED POPULATION ELIGIBLE MONTHS	TOTAL POPULATION ELIGIBLE MONTHS
SSI Aged	2,089,314	381,620	2,470,934
SSI Blind & Disabled	1,035,608	2,942,080	3,977,688
ADC Adults	7,807	4,576,582	4,584,389
ADC/HR Children	10,762	11,590,280	11,601,042
MA SSI Aged	1,772,775	91,857	1,864,632
MA SSI Blind & Disabled	616,740	253,253	869,993
MA ADC Adults	151,111	1,035,805	1,186,916
MA-ADC/MA HR Children	277,155	3,462,806	3,739,961
HR Adults	20,681	3,406,586	3,427,267
MA HR Adults	5,932	737,670	743,602
Total	5,987,885	28,478,539	34,466,424
			17.37%

	EXEMPT POPULATION ALL SERVICES EXPENDITURES	INCLUDED POPULATION NON-COVERED SERVICES EXPENDITURES	INCLUDED POPULATION COVERED SERVICES EXPENDITURES	TOTAL
SSI Aged	89.47%	3.17%	7.36%	100.00%
SSI Blind & Disabled	46.86%	5.57%	47.58%	100.00%
ADC Adults	0.56%	0.17%	99.27%	100.00%
ADC/HR Children	4.40%	5.12%	90.48%	100.00%
MA SSI Aged	98.43%	0.26%	1.31%	100.00%
MA SSI Blind & Disabled	84.05%	0.61%	15.34%	100.00%
MA ADC Adults	13.17%	0.05%	86.78%	100.00%
MA-ADC/MA HR Children	10.46%	1.11%	88.43%	100.00%
HR Adults	4.44%	0.81%	94.76%	100.00%
MA HR Adults	0.00%	0.70%	92.31%	100.00%

	EXEMPT POPULATION ELIGIBLE MONTHS	INCLUDED POPULATION ELIGIBLE MONTHS	TOTAL POPULATION ELIGIBLE MONTHS
SSI Aged	84.56%	15.44%	100.00%
SSI Blind & Disabled	26.04%	73.96%	100.00%
ADC Adults	0.17%	99.83%	100.00%
ADC/HR Children	0.09%	99.91%	100.00%
MA SSI Aged	95.07%	4.93%	100.00%
MA SSI Blind & Disabled	70.89%	29.11%	100.00%
MA ADC Adults	12.73%	87.27%	100.00%
MA-ADC/MA HR Children	7.41%	92.59%	100.00%
HR Adults	0.60%	99.40%	100.00%
MA HR Adults	0.80%	99.20%	100.00%

Appendix 5.E

HISTORICAL, AND PROJECTED PMPM COST DATA

Appendix E: Medical Assistance Program
Actual Expenditures per Eligible from FY 1989-89 to 1993-94
Projected Expenditures per Eligible from 1994-95 to 1999-2000
Summary Reports
Gross
New York State

	FY 1989-89	FY 1989-90	FY 1990-91	FY 1991-92	FY 1992-93	FY 1993-94	FY 1994-95	FY 1995-96	FY 1996-97	FY 1997-98	FY 1998-99	FY 1999-2000
Monthly Cost per Eligible												
SSI - Aged & Disabled	\$718	\$806	\$829	\$1,050	\$984	\$1,010	\$1,167	\$1,248	\$1,308	\$1,419	\$1,538	\$1,668
SSI - Blind & Disabled	\$771	\$864	\$885	\$1,025	\$964	\$985	\$1,104	\$1,233	\$1,328	\$1,447	\$1,578	\$1,716
ADCH - Children	\$149	\$171	\$202	\$225	\$207	\$210	\$235	\$255	\$260	\$271	\$271	\$289
MA-SSI - Aged	\$78	\$97	\$110	\$128	\$136	\$137	\$157	\$170	\$182	\$198	\$210	\$227
MA-SSI - Blind & Disabled	\$1,722	\$1,871	\$2,123	\$2,320	\$2,378	\$2,449	\$2,817	\$3,188	\$3,312	\$3,682	\$3,998	\$4,343
MA-ADC - Adult	\$2,042	\$2,300	\$2,658	\$2,738	\$2,935	\$2,814	\$3,222	\$3,516	\$3,612	\$3,959	\$4,198	\$4,543
MA-ADC / MA-HR - Children	\$341	\$417	\$440	\$440	\$478	\$417	\$442	\$471	\$504	\$539	\$577	\$618
MA-ADC - Adult	\$396	\$419	\$432	\$440	\$478	\$417	\$442	\$471	\$504	\$539	\$577	\$618
HR - Adults	\$213	\$190	\$228	\$255	\$265	\$231	\$228	\$245	\$264	\$284	\$305	\$327
MA-HR - Adults	\$0	\$0	\$0	\$0	\$388	\$385	\$414	\$444	\$477	\$512	\$551	\$593
DSH	\$0	\$0	\$0	\$0	\$607	\$643	\$642	\$684	\$728	\$777	\$828	\$884
Subtotal: FY Current \$/Eligible Excluding DSH	\$443	\$474	\$529	\$578	\$567	\$582	\$639	\$679	\$712	\$765	\$822	\$883
Subtotal: FY Current \$/Eligible Including DSH	\$386	\$419	\$485	\$508	\$478	\$435	\$482	\$518	\$553	\$574	\$618	\$666
Total: Current \$/Eligible Excluding DSH	\$404	\$435	\$492	\$508	\$478	\$435	\$482	\$518	\$553	\$574	\$618	\$666
Total: Current \$/Eligible Including DSH	\$404	\$435	\$492	\$508	\$478	\$435	\$482	\$518	\$553	\$574	\$618	\$666
The Changes in Monthly Cost per Eligible												
SSI - Aged	\$87	\$86	\$124	\$121	(\$90)	\$82	\$141	\$88	\$62	\$110	\$120	\$130
SSI - Blind & Disabled	\$22	\$112	\$32	\$71	(\$10)	\$39	\$111	\$86	\$86	\$118	\$129	\$140
ADCH - Adult	\$0	\$22	\$32	\$33	(\$29)	\$7	\$13	\$11	\$11	\$16	\$16	\$18
ADCH - Children	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
MA-SSI - Aged	\$148	\$232	\$197	\$197	\$27	\$22	\$368	\$214	\$177	\$223	\$252	\$273
MA-SSI - Blind & Disabled	\$238	\$282	\$322	\$348	\$184	(\$19)	\$108	\$214	\$177	\$223	\$252	\$273
MA-ADC - Adult	\$238	\$282	\$322	\$348	\$184	(\$19)	\$108	\$214	\$177	\$223	\$252	\$273
MA-ADC - Adult	\$238	\$282	\$322	\$348	\$184	(\$19)	\$108	\$214	\$177	\$223	\$252	\$273
MA-ADC / MA-HR - Children	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
MA-ADC - Adult	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
MA-HR - Adults	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
DSH	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Subtotal: FY Current \$/Eligible Excluding DSH	\$31	\$65	\$65	\$48	(\$11)	\$16	\$57	\$40	\$33	\$63	\$67	\$81
Subtotal: FY Current \$/Eligible Including DSH	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Subtotal: Current \$/Eligible Excluding DSH	\$31	\$65	\$65	\$48	(\$11)	\$16	\$57	\$40	\$33	\$63	\$67	\$81
Total: Current \$/Eligible Including DSH	\$31	\$65	\$65	\$48	(\$11)	\$16	\$57	\$40	\$33	\$63	\$67	\$81
The Growth Rates of Monthly Cost per Eligible												
SSI - Aged	12.10%	15.39%	15.39%	12.97%	-4.19%	6.40%	13.89%	7.67%	6.01%	8.41%	8.41%	8.43%
SSI - Blind & Disabled	8.42%	13.35%	13.35%	7.49%	-0.85%	3.72%	10.60%	6.95%	7.69%	8.80%	8.80%	8.80%
ADCH - Adult	14.75%	18.49%	18.49%	11.42%	-12.82%	3.44%	6.29%	6.09%	6.89%	8.00%	8.00%	8.00%
ADCH - Children	11.72%	25.35%	17.19%	17.19%	1.15%	1.15%	14.82%	-0.85%	6.87%	6.23%	6.30%	6.30%
MA-SSI - Aged	8.89%	13.48%	8.30%	8.30%	2.47%	2.89%	15.04%	12.46%	3.89%	9.82%	9.76%	9.71%
MA-SSI - Blind & Disabled	12.85%	11.19%	7.07%	7.07%	7.09%	-4.05%	3.85%	7.32%	6.86%	7.53%	7.14%	7.15%
MA-ADC - Adult	-10.75%	18.57%	18.57%	13.11%	-14.56%	11.03%	6.85%	6.75%	6.82%	7.00%	7.06%	7.17%
MA-ADC / MA-HR - Children												
MA-ADC - Adult												
MA-HR - Adults												
DSH												
Subtotal: FY Current \$/Eligible Excluding DSH	6.90%	11.71%	11.71%	6.19%	-1.89%	2.71%	9.71%	6.32%	4.82%	7.39%	7.40%	7.45%
Subtotal: FY Current \$/Eligible Including DSH	6.75%	11.13%	11.13%	8.76%	8.22%	3.00%	8.49%	7.26%	7.42%	7.87%	7.73%	7.73%
Total: Current \$/Eligible Excluding DSH	7.50%	13.25%	13.25%	21.98%	4.53%	2.19%	-3.85%	6.56%	5.29%	7.65%	7.65%	7.65%
Total: Current \$/Eligible Including DSH												

actual
projected

Appendix 5.F

HISTORICAL AND PROJECTED AGGREGATE COST DATA

**Appendix 5F: Medical Assistance Program
Actual Expenditures from FY 1982-83 to 1993-94
Projected Expenditures from 1994-95 to 1999-2000**

Annual Total Expenditures	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000
SSI - Aged	\$1,379,818,861	\$1,502,466,318	\$1,780,973,900	\$2,052,243,348	\$1,948,988,910	\$2,103,868,923	\$2,450,584,622	\$2,710,248,529	\$2,914,980,591	\$3,238,367,356	\$3,598,579,036	\$3,998,772,313
SSI - Blind & Disabled	\$2,315,621,056	\$2,620,635,977	\$3,228,887,609	\$3,892,539,188	\$4,375,627,844	\$5,013,764,782	\$5,924,994,082	\$6,745,153,160	\$7,913,560,089	\$9,456,207,504	\$11,305,277,696	\$13,487,498,642
ADC - Adult	\$349,083,631	\$620,700,659	\$792,016,546	\$941,581,291	\$893,516,313	\$986,097,366	\$1,160,988,275	\$1,226,652,055	\$1,369,143,332	\$1,540,873,959	\$1,741,311,126	\$1,970,946,808
ADCHH - Children	\$714,106,772	\$1,094,233,333	\$1,359,006,974	\$1,359,006,974	\$1,359,006,974	\$1,359,006,974	\$1,359,006,974	\$1,359,006,974	\$1,359,006,974	\$1,359,006,974	\$1,359,006,974	\$1,359,006,974
MA-SSI - Aged	\$3,056,829,065	\$3,340,732,658	\$3,787,610,640	\$4,209,827,563	\$4,327,327,291	\$4,520,803,023	\$5,984,419,870	\$6,197,330,380	\$6,197,330,380	\$6,800,153,589	\$7,459,559,964	\$8,180,976,459
MA-SSI - Blind & Disabled	\$1,685,696,337	\$1,901,435,943	\$2,216,229,261	\$2,216,229,261	\$2,216,229,261	\$2,216,229,261	\$2,216,229,261	\$2,216,229,261	\$2,216,229,261	\$2,216,229,261	\$2,216,229,261	\$2,216,229,261
MA-ADC - Adult	\$263,270,546	\$293,728,637	\$498,818,010	\$455,261,448	\$455,261,448	\$455,261,448	\$455,261,448	\$455,261,448	\$455,261,448	\$455,261,448	\$455,261,448	\$455,261,448
MA-ADC / MA-HR - Children	\$590,021,035	\$631,966,987	\$887,832,821	\$1,110,061,761	\$1,056,421,868	\$1,151,833,354	\$1,271,216,034	\$1,492,437,407	\$1,768,798,430	\$2,095,775,824	\$2,471,704,014	\$2,879,690,259
HR - Adults	\$0	\$0	\$0	\$0	\$0	\$1,351,155,407	\$1,405,809,173	\$1,601,031,433	\$1,708,556,170	\$1,827,781,216	\$1,959,971,482	\$2,105,346,877
MA-HR - Adults	\$217,983,462	\$442,176,004	\$814,809,340	\$3,087,319,516	\$466,226,988	\$466,226,988	\$620,083,023	\$677,552,981	\$756,737,410	\$947,601,893	\$947,601,893	\$1,060,032,020
DSH	\$0	\$0	\$0	\$0	\$0	\$2,831,864,000	\$2,831,864,000	\$0	\$0	\$0	\$0	\$0
Subtotal: FP Current & Excluding DSH	\$10,504,447,292	\$11,744,838,636	\$14,192,412,780	\$16,606,777,986	\$17,354,056,396	\$18,806,427,706	\$21,753,406,008	\$24,363,011,784	\$27,066,397,783	\$30,876,594,052	\$35,255,558,809	\$40,386,419,566
Subtotal: HR Current & Excluding DSH	N/A	N/A	N/A	N/A	\$1,764,736,571	\$1,941,994,341	\$2,115,894,196	\$2,278,584,413	\$2,463,313,381	\$2,675,383,108	\$2,907,512,901	\$3,163,378,898
Subtotal: Current & Excluding DSH	\$10,504,447,292	\$11,744,838,636	\$14,192,412,780	\$16,606,777,986	\$19,128,812,967	\$20,748,422,048	\$23,851,300,205	\$26,641,596,197	\$29,531,711,563	\$33,551,977,160	\$38,163,071,711	\$43,551,798,664
Total: Current & Including DSH	\$10,732,430,754	\$12,187,014,640	\$15,007,222,120	\$19,694,097,502	\$21,913,289,967	\$23,580,286,048	\$23,851,300,205	\$26,641,596,197	\$29,531,711,563	\$33,551,977,160	\$38,163,071,711	\$43,551,798,664
The Changes in Annual Total Expenditure												
SSI - Aged	\$172,647,656	\$278,407,382	\$278,407,382	\$271,269,449	\$(103,254,438)	\$156,980,013	\$344,715,699	\$259,663,907	\$204,732,063	\$323,396,944	\$360,161,300	\$400,193,278
SSI - Blind & Disabled	\$304,814,941	\$608,431,632	\$608,431,632	\$663,471,579	\$483,268,657	\$638,136,938	\$911,230,200	\$820,158,178	\$1,168,406,929	\$1,342,607,413	\$1,849,070,192	\$2,182,230,946
ADC - Adult	\$71,617,047	\$171,316,248	\$171,316,248	\$149,564,344	\$(84,632,972)	\$91,651,047	\$113,960,900	\$126,033,782	\$142,201,851	\$171,730,033	\$200,257,167	\$229,815,682
ADCHH - Children	\$98,465,387	\$285,680,994	\$285,680,994	\$264,803,631	\$146,456,888	\$69,033,139	\$287,206,713	\$677,829,947	\$192,380,064	\$256,399,080	\$256,399,080	\$256,399,080
MA-SSI - Aged	\$286,702,553	\$444,079,072	\$444,079,072	\$422,219,212	\$112,497,438	\$196,476,309	\$795,756,423	\$667,839,943	\$212,930,310	\$602,804,797	\$659,406,375	\$721,366,096
MA-SSI - Blind & Disabled	\$215,739,316	\$316,793,419	\$316,793,419	\$324,598,301	\$314,431,291	\$63,016,593	\$284,027,501	\$391,793,808	\$197,308,857	\$356,730,073	\$601,016,631	\$601,016,631
MA-ADC - Adult	\$108,879,613	\$108,879,613	\$108,879,613	\$96,209,760	\$(46,256,567)	\$79,761,603	\$27,680,339	\$85,827,347	\$114,094,707	\$127,436,361	\$149,011,579	\$173,898,932
MA-ADC / MA-HR - Children	\$335,863,834	\$335,863,834	\$335,863,834	\$222,228,939	\$(103,639,892)	\$145,413,666	\$119,380,519	\$221,241,354	\$269,341,023	\$317,977,395	\$367,928,190	\$432,226,315
HR - Adults	\$0	\$0	\$0	\$0	\$1,295,729,362	\$96,625,824	\$100,633,766	\$105,222,260	\$117,977,357	\$119,225,045	\$132,175,987	\$145,389,695
MA-HR - Adults	\$0	\$0	\$0	\$0	\$466,226,988	\$80,611,946	\$73,246,099	\$77,467,957	\$79,204,433	\$90,844,482	\$99,953,826	\$112,476,302
DSH	\$0	\$0	\$0	\$0	\$(302,842,516)	\$47,387,000	\$(2,831,864,000)	\$0	\$0	\$0	\$0	\$0
Subtotal: FP Current & Excluding DSH	\$1,240,391,344	\$2,441,574,144	\$2,441,574,144	\$2,414,365,206	\$757,278,410	\$1,442,317,310	\$2,928,978,932	\$2,639,605,776	\$2,701,385,999	\$4,378,964,728	\$5,030,861,137	\$5,861,961,596
Subtotal: HR Current & Excluding DSH	\$0	\$0	\$0	\$0	\$177,237,770	\$171,899,851	\$167,690,311	\$167,690,311	\$186,729,167	\$210,969,529	\$232,129,391	\$267,863,996
Subtotal: Current & Excluding DSH	\$1,240,391,344	\$2,441,574,144	\$2,441,574,144	\$2,414,365,206	\$2,232,034,981	\$1,619,699,081	\$3,102,878,157	\$2,792,295,993	\$2,888,115,166	\$4,020,265,397	\$4,611,094,531	\$5,288,727,133
Total: Current & Including DSH	\$1,464,583,886	\$2,820,207,480	\$2,820,207,480	\$4,686,875,382	\$2,215,192,465	\$1,666,596,081	\$2,771,014,157	\$2,792,295,993	\$2,888,115,166	\$4,020,265,397	\$4,611,094,531	\$5,288,727,133
The Growth Rates of Annual Total Expenditures												
SSI - Aged	12.98%	12.98%	18.54%	15.23%	-5.03%	8.05%	16.37%	10.60%	7.55%	11.09%	11.2%	11.2%
SSI - Blind & Disabled	13.16%	13.16%	23.22%	20.55%	12.42%	14.38%	18.17%	13.84%	17.32%	19.49%	19.3%	19.3%
ADC - Adult	13.04%	27.60%	37.00%	18.88%	-4.92%	10.24%	11.55%	11.55%	11.55%	12.54%	13.09%	13.2%
ADCHH - Children	13.51%	35.00%	24.20%	10.78%	4.59%	18.24%	3.06%	12.50%	10.03%	10.94%	11.7%	12.0%
MA-SSI - Aged	9.38%	13.28%	11.1%	2.67%	1.1%	4.59%	17.60%	12.50%	3.50%	9.7%	9.7%	9.7%
MA-SSI - Blind & Disabled	12.80%	16.66%	14.63%	12.37%	2.21%	9.73%	12.23%	12.23%	11.05%	12.53%	13.9%	14.0%
MA-ADC - Adult	11.57%	37.07%	23.90%	25.03%	-9.24%	14.45%	14.19%	14.19%	16.31%	18.05%	17.6%	18.0%
MA-ADC / MA-HR - Children	10.50%	36.18%	36.18%	25.03%	-9.34%	7.44%	7.03%	7.03%	6.72%	6.98%	7.42%	7.42%
HR - Adults						17.59%	13.39%	9.27%	11.69%	12.09%	11.79%	11.87%
MA-HR - Adults						1.70%	-100.00%					
DSH												
Subtotal: FP Current & Excluding DSH	11.81%	11.81%	20.84%	17.01%	4.56%	8.31%	15.57%	12.0%	11.0%	14.0%	14.1%	14.2%
Subtotal: HR Current & Excluding DSH	11.81%	11.81%	20.84%	17.01%	8.35%	10.04%	8.35%	7.69%	8.19%	8.57%	8.68%	8.87%
Subtotal: Current & Excluding DSH	13.66%	13.66%	23.14%	20.84%	15.19%	8.47%	14.95%	13.1%	10.84%	13.61%	13.74%	13.86%
Total: Current & Including DSH						7.61%	1.95%	11.71%	10.84%	13.61%	13.74%	13.86%

Appendix 5.G

DETAILED ADMINISTRATIVE EXPENSE

MANAGED CARE ADMINISTRATION ESTIMATES

CATEGORIES OF EXPENSE	OCT-DEC 1992	JAN-MAR 1993	APR-JUN 1993	JUL-SEP 1993	TOTAL FFY1993	OCT-DEC 1993	JAN-MAR 1994	APR-JUN 1994	JUL-SEP 1994	TOTAL FFY1994	OCT-DEC 1994	JAN-MAR 1995	APR-JUN 1995	JUL-SEP 1995	TOTAL FFY1995
A. BASE STATEWIDE MA ADMIN															
GROSS	133,875	140,806	151,424	158,408	584,113	164,282	150,849	184,744	136,100	635,185	154,886	188,165	157,905	158,739	659,695
FEDERAL SHARE	79,360	80,036	85,909	88,324	333,629	92,774	85,921	102,823	71,857	353,375	93,135	109,747	93,293	95,021	391,196
B. COSTS FOR NEW ELIGIBLES (INCREMENTAL DISTRICT COSTS)															
GROSS	39,295	23,328	20,785	28,793	110,201	23,857	27,888	24,003	26,746	102,494	26,992	29,963	26,814	31,033	114,803
FEDERAL SHARE	19,648	11,864	10,393	13,397	55,101	11,929	13,944	12,002	13,373	51,247	13,346	14,982	13,407	15,517	57,251
C. NEW EDP COSTS: MGD CARE															
GROSS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
FEDERAL SHARE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
D. NEW FFP COSTS: STATE AGENCIES															
GROSS	9,500	9,500	9,500	9,500	38,000	10,000	10,000	10,000	10,000	40,000	10,500	10,500	10,500	10,500	42,000
FEDERAL SHARE	4,750	4,750	4,750	4,750	19,000	5,000	5,000	5,000	5,000	20,000	5,250	5,250	5,250	5,250	21,000
TOTAL															
GROSS	182,470	173,434	181,709	194,701	732,314	198,119	187,937	218,747	172,846	777,649	191,878	228,828	195,219	200,272	816,998
FEDERAL SHARE	103,758	96,450	101,052	108,471	407,730	109,703	104,866	119,825	90,230	424,622	111,731	129,979	111,980	115,788	469,447

Estimates do not include costs of evaluation that may be required.

CATEGORIES OF EXPENSE	OCT.-DEC 1995			JAN.-MAR 1996			APR.-JUN 1996			JUL.-SEP 1996			TOTAL FFY1996			OCT.-DEC 1997			JAN.-MAR 1998			APR.-JUN 1998			JUL.-SEP 1998			TOTAL FFY1998		
A. BASE STATEWIDE MA ADMIN																														
GROSS	162,497	157,166	166,169	166,169	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	161,210	
FEDERAL SHARE	97,498	94,299	99,701	99,701	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	96,092	
B. COSTS FOR NEW ELIGIBLES (INCREMENTAL DISTRICT COSTS)																														
GROSS	27,759	31,161	27,887	27,887	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	32,275	
FEDERAL SHARE	13,860	15,581	13,944	13,944	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	16,136	
C. NEW EDP COSTS: MGD CARE																														
GROSS	1,800	1,800	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	
FEDERAL SHARE	1,620	1,620	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	2,340	
D. NEW COSTS: STATE AGENCIES																														
GROSS	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	11,000	
FEDERAL SHARE	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	5,500	
TOTAL	203,056	201,127	207,656	207,656	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	
GROSS	116,498	117,000	121,465	121,465	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	120,070	
FEDERAL SHARE	203,056	201,127	207,656	207,656	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	
TOTAL	203,056	201,127	207,656	207,656	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	207,085	
GROSS	216,937	214,836	220,994	220,994	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	
FEDERAL SHARE	124,459	122,888	126,840	126,840	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	126,457	
TOTAL	216,937	214,836	220,994	220,994	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	221,068	

Estimates do not include costs of evaluation that may be required.

CATEGORIES OF EXPENSE	MANAGED CARE ADMINISTRATION ESTIMATES											
	OCT-DEC 1998	JAN-MAR 1999	APR-JUN 1999	JUL-SEP 1999	TOTAL FFY1999	OCT-DEC 1999	JAN-MAR 2000	APR-JUN 2000	JUL-SEP 2000	TOTAL FFY 2000		
	1998	1999	1999	1999	FFY1999	1999	2000	2000	2000	FFY 2000		
U. BASE STATEWIDE MA ADMIN												
GROSS	180,635	174,569	184,685	179,789	719,678	187,414	181,049	191,599	186,469	746,532		
FEDERAL SHARE	106,575	102,996	108,964	106,076	424,610	110,574	106,819	113,044	110,017	440,454		
F. COSTS FOR NEW ELIGIBLES (INCREMENTAL DISTRICT COSTS)												
GROSS	31,228	35,053	31,370	36,306	133,955	32,475	36,456	32,625	37,758	139,314		
FEDERAL SHARE	15,613	17,527	15,685	18,153	66,977	16,238	18,228	16,313	16,979	69,857		
C. NEW EDP COSTS: MGD CARE												
GROSS	850	850	850	850	3,400	900	900	900	900	3,600		
FEDERAL SHARE	765	765	765	765	3,060	810	810	810	810	3,240		
D. NEW COSTS: STATE AGENCIES												
GROSS	12,500	12,500	12,500	12,500	50,000	13,000	13,000	13,000	13,000	52,000		
FEDERAL SHARE	6,250	6,250	6,250	6,250	25,000	6,500	6,500	6,500	6,500	26,000		
TOTAL												
GROSS	225,211	222,972	229,405	229,445	907,033	233,789	231,405	238,124	238,127	941,446		
FEDERAL SHARE	129,203	127,537	131,664	131,244	519,648	134,122	132,357	136,866	136,206	539,551		

Estimates do not include costs of evaluation that may be required.